Interdependent Discourses of Disability

A Critical Analysis of the Social/Medical Model Dichotomy

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Contents

Preface and acknowledgements

Even the best doctoral thesis constitutes a very small contribution to a very large amount of knowledge. This thesis is meant to make its contribution partly by drawing connections between two fields. As such it is a potential object of criticism from two directions, but also the beneficiary of advice and assistance from both its families proper and from friendly in-laws.

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Before and after Berkeley, my academic home has been at Oslo University College and the University of Oslo. At the former institution, I

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JG

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Part I: Introduction

Chapter 1: Preliminaries

This is the final contribution and extended introduction[1] to the thesis, the purpose of which is to summarize, expand upon, and to some extent update, the four articles that constitute the previously published material. The introduction will provide a measure of background and coherence that must be omitted in the usual peer review format, and will give a sense of the overall contribution of the research project.

The introduction consists mainly of discussions of disability studies, discourse analysis, and rhetoric that are intended as supplements to the articles themselves. These three disciplines inform the articles in various ways, by providing the research problems, the theoretical apparatus, and the methodologies, and it is necessary to discuss both these functions and key aspects of the disciplines as they relate to each other.

Disability: A complex phenomenon

This thesis is an investigation into the current meaning of disability and of some forms of contemporary disability discourse. "Disability", as a word and as a concept, is neither defined easily nor used consistently, and although there are a substantial tradition and literature of *disability studies* (Davis 2006), there is much that is ambiguous or contested in terms of both usage and comprehension. Disability has been a topic in disciplines that range from medicine to sociology and anthropology, but the (relatively recent) emergence of disability studies as an independent field has made it clear that disability means something very different in each of those disciplines.

[1] There is, to the best of the author's knowledge, no universally agreed-upon descriptor for the part of an article-based PhD thesis that precedes the articles. The term "final contribution" is used in many Scandinavian contexts, whereas the more common term internationally appears to be simply "introduction". The term "final contribution" is included here as a reminder that these pages were written following the publication or acceptance for publication of all included articles; henceforth, the term "introduction" will be used.

This is one of the factors that make the meaning of disability a suitable area of investigation for a language researcher. Disability is sometimes, both in everyday speech and in some professional contexts, understood to mean simply a physical or mental impairment (or the result of same, see WHO 1980), that is, to describe a condition limited to individuals and individual bodies. A major goal of the following is to support the case that it is a complex concept, which cannot be properly understood without reference to similarly complex mechanisms of language and discourse. Another factor is the strong but narrow salience of disability discourse. Such discourse is produced across a great range of fields, including not only the social sciences and the humanities, but also government, the law, and medicine. Disability is a singularly important concept in most modern welfare states (Stone 1984), but also throughout cultural history (Stiker 1999 [1982]). More often than not, however, and more so than with topics like ethnicity and gender, disability is under-discussed by academics and professionals who do not specialize in it. Much in the same way that many disability accommodations and access technologies (e.g., screen readers or para-transit) are all but unknown to those who do not need to use them, disability appears rarely or not at all in research traditions where it could be explored in interesting ways. I consider discourse analysis one of those traditions (I expand the argument in Article IV); this thesis is an attempt to remedy the omission.

This study deals primarily with discourse, that is, language use as a form of social practice (Fairclough 1992; Fairclough 2001 [1989]; van Dijk 1997). The material for the study is *texts*, whether transcribed, printed, or published; they have been read, analyzed and discussed with an emphasis on their social and political meanings in particular contexts. I have approached the material from an interdisciplinary viewpoint, but this study does not engage extensively with either the philosophy of disability (see Kristiansen, Vehmas, and Shakespeare 2009 for such perspectives) or the social, political, and economic consequences of the texts under analysis (see Oliver 1996), though discourse analysis leads at times in both those directions. My choice has been to concentrate on forms of textual practice,

in order to provide as clear a picture as possible of how disability is currently understood in key social and political fields.
The study's empirical scope is limited to the NGO (non-governmental organization) field in Norway. As a member of a community of less than 5 million native speakers of Norwegian, I have access to data that is not available to most practitioners of discourse analysis. Moreover, as I discuss more extensively in Article I, Norwegian NGO discourse is the site of an encounter between two rather different approaches to disability. The Scandinavian research tradition, of which Norway is a part, has its own theories, models and approaches – due largely, of course, to the welfare state. In recent years, however, the influence of Anglo-American schools of thought has been strongly felt. This influence coincides with an increase in the discourse of disability and civil rights in policy language, a topic I address more closely in Article II). The Norwegian texts should be interesting to an international audience because they are in dialogue with UK and US thought on disability, while presenting an alternative perspective that is equally viable and legitimate.

This thesis is thus situated at a crossroads, alternately exploring the topic of disability in a forum for language research (Articles I, III, IV), and employing discourse analysis in the context of disability studies (Article II). Although the need for disability research written by and for specialists is as great as ever, I have found the need for interdisciplinary dialogue to be equally great. In one sense, the state of disability studies today is similar to that of gender studies some decades ago.

It is the goal of many scholars, including myself, that the concept of disability should evolve in two ways: (1) by becoming an analytical category that is employed across the humanities and social sciences, whether in history, sociology or language studies, and (2) by becoming the study object of a discipline with many points of contact with researchers in those fields. These developments have been taking place for some time, and with this study I hope to contribute to them.

Research areas and research questions

The history, sociology and philosophy of disability are still being written. It is a history of, to a name a few key phenomena, repression, marginalization, institutionalization, mobilization, and liberation (not always in that order). Some of its canonical works date back two or three decades (Oliver 1990; Stiker 1999 [1982]; Zola 1989), some are older still (Goffman 1963; UPIAS 1976), but the majority of studies are considerably newer. Much of the writing on disability has been produced by medical professionals and bureaucrats; in the modern age disability has been, probably more than anything else, a category of administration, medical intervention, and rehabilitation. The texts that document the existence and consequences of this category are to a great extent documents of the state and of governmental institutions.

As disabled people have organized themselves, however, a considerable amount of text has been produced in the non-governmental sector, aka the civil sector or third sector. A Norwegian representative of that sector is the chief provider of data for this study. The organization is the Norwegian Federation of Organisations of Disabled People, hereafter referred to as FFO. It was founded on September 21, 1950 as an umbrella organization for what was then termed the "partly employable". Since its inception, FFO has expanded its membership to include, at the time of writing, 71 member organizations with more than 330,000 individual members. FFO is the most important Norwegian disability NGO, and interacts with the Norwegian state on most disability issues. It consults on legislation, acts as a negotiation partner, and represents the mutual interests both of people with a wide range of medical diagnoses and of people who reject the medicalization of disability entirely.

The research questions that motivated this thesis originated in tensions that are inherent in FFO's structure and role: How do medical, social, and political discourses shape the current meaning of disability? How is the meaning of disability produced in and by texts? While FFO has adopted a policy and a language that prioritize equal rights, anti-discrimination, and a non-medical view of disability (see Article I), it represents many organizations that understand the life situations and the

needs of their members largely in medical terms (see Article III). There is, in other words, a potential conflict between organizational language and worldviews. The question is whether this tension is a productive one, but also what present NGO language can tell us about the future. What will disability mean in years to come, and what will it mean to be disabled?

Thesis structure and the research process

The thesis's four research articles provide four different points of entry for exploring the meaning of disability. They were written on the basis of documents authored by FFO (Article I), Norwegian legislation for which FFO lobbied, along with other organizations and advocates (Article II), and interviews with professionals in the FFO system (Article III). This division of labor is not least due to the original brief for the Research Council of Norway project, entitled "Rehabilitation as Conflicted" and located at Oslo University College's Faculty of Health Sciences, which has funded my research over the past four years.

While I began the research process with a clear focus on the FFO system, my concerns and interests expanded over time – a process that is reflected in the articles. Article I, "Critical discourse analysis, topoi and mystification: Disability policy documents from a Norwegian NGO", is a close reading of FFO's programmatic documents, its bylaws and a selection of consultative statements. Article II, "Is there something wrong with society, or is it just me? Social and medical knowledge in a Norwegian anti-discrimination law", deals with a recent piece of legislation which integrates the anti-discrimination perspective with traditional welfare state mechanisms. Article III, "False Dichotomies of Disability Politics: Theory and Practice in the Discourse of Norwegian NGO Professionals", explores the relationship between disability theory as perceived in academe and in the FFO system. Article IV, "Disability and discourse analysis: Some topics and issues", surveys disability studies literature and critically examines some of the major disputes between different theories and models of disability. This change of scope was accelerated by my introduction to interdisciplinary disability studies, both in Norway and at the University of California at Berkeley, where I spent the academic year 2008–2009 as a

visiting student researcher. It is all but impossible to engage with current research on disability without wanting to explore the issues of identity that emerge from NGO structures and policies, and as time went on, I have found them to be central to the topic at hand.

The remaining chapters in this introduction are intended to justify both the thesis's expanding scope and its overarching concerns. Following this introduction, in chapter 2, I discuss the analytical framework. This discussion includes a) a summary of the state and major findings of disability studies, b) a summary of the thesis's theoretical grounding in discourse analysis and rhetoric, c) methodological considerations and notes on the case study approach, and d) some reflections on the benefits and perils of interdisciplinarity. Chapter 3 provides more detailed article summaries, including notes and revisions, and summarizes the analyses, concluding with a brief discussion of disability as an interdisciplinary subject.

Chapter 2: Framework

This chapter discusses the overarching goals of the thesis, and three disciplines on which its theoretical and methodological structure depends: Discourse analysis, rhetoric and disability studies.

Theory and goals

This thesis is primarily a work of discourse analysis. Since that concept has been extensively employed in a considerable range of disciplines in both the social sciences and the humanities, it will be useful to discuss the particularities of discourse analysis as a form of research on language and language use, and the ways in which this form of discourse analysis distinguishes itself from other research traditions. Teun van Dijk, one of the foremost practitioners of discourse analysis, has argued that it is, to all intents and purposes, not really a form of analysis but a "domain of scholarly practice" (van Dijk 2008: 2); this is the understanding that will be adopted in the following. "Discourse" has been approached as an analytical unit by various schools and traditions of language research – most of which have a shared view of language as a fundamentally social phenomenon, and employ similar descriptive and analytical tools. Thus, the viewpoint from which the articles in this thesis were written should be alien to neither rhetoric nor pragmatics. What follows, then, is an account of the major directions in language research that inform this viewpoint.

As the oldest systematic study of language in use, rhetoric looms large over the history of discourse analysis. It is also the topic of a literature too vast to address in this context except where it impinges directly on the thesis's analytical concerns. Twentieth century *new rhetoric* in particular (Burke 1945; Burke 1950; Perelman and Olbrechts-Tyteca 1969), with its focus on context and argumentation, provides a cultural-historical grounding for the concerns and techniques of linguistics-originated discourse analysis, while perennial Aristotelian analytical categories such as *ethos*, *logos*, and *pathos* can prove useful in linking this form of discourse analysis with specific producers and consumers of discourse. The author of these pages is part of a research group in which linguists and rhetoricians understand, respect and often find useful the terminology of their

neighboring disciplines; the analytical approach of that community should not be underestimated.

The discourse analysis that began to take shape as a discipline under that name from the 1960s onwards, partly in conjunction with developments in sociolinguistics and pragmatics, arose at least semi-independently as the linguistic study of connections and patterning beyond the level of the sentence (Harris 1952). The question is whether that form of discourse analysis should be treated as functionally independent *today*, as the basis of a separate way to do language research, or whether it should be treated as part of a broader intellectual history in which multiple approaches to the study of language converge on language-in-context and language-in-use; the latter approach will be adopted in the following. The interest in contextually situated language that was exhibited by the Bakhtin school in the Soviet Union in the 1920s and 1930s (see Bakhtin, Morris, Voloshinov, and Medvedev 1994; Voloshinov 1986 [1929]) is not radically different either from the earlier work of Ferdinand de Saussure on the social aspect of the language system (see Harris 2003; Saussure 1959 [1916]; 2006). Even the formalist approach that is pioneered in Zelig Harris's 1952 article eventually gravitated toward the study of meaning – and as pragmatics expanded (Austin 1962; Brown and Levinson 1987; Grice 1975; 1989; Searle 1969), so meaning became contextual and social.

The late 20th century growth of interest in language as a social phenomenon, and particularly in discourse analysis, can probably be explained by both intellectual-internal and technological-external causes. Arguably, Saussure's ur-distinction between *langue* and *parole* led to the mainstream of linguistics research focusing on aspects of language that could be represented in formalized notation. Language in the abstract wins out over language in use because of the difficulty of establishing clear and consistent methodological principles for the latter and the relative ease of data production in the former (Harris 1993; Sampson 1980). The advent of tape recorders was necessary before language in use could be studied effectively and conversation analysis could establish itself as a discipline; by the time this had happened, philosophers and sociologists were taking the

linguistic turn, and so were ready and willing to approach language-in-use themselves.

Against this background, it is certainly hard, perhaps impossible, and quite likely counterproductive, to delineate a form of discourse analysis that is purely a form of language research. The form of discourse analysis as scholarly practice that is adopted in this thesis is better described as being organized around three basic definitions of its research objects:

1) In the context of this thesis, "discourse" is understood to be *language, whether spoken or written, in its social context of use*. Variations on this definition include discourse analysis pertaining to language as a "social practice determined by social structures" (Fairclough 2001 [1989]:14) or as a "situated interaction, as a social practice, or as a type of communication in a social, cultural, historical or political situation" (van Dijk 2008:3).
2) A *discourse object*, is a text, for example an interview, a web page, an article or a book situated in a social context. Such discourse objects rely for their meaning on other discourse objects, as well as on their intended and incidental readerships, their authorship and place of publication, and conventions of genre and use.
3) Beyond this level, *discourses* plural (alternatively, "orders of discourse") exist as socially efficacious networks of meaning. Medical discourse, for example, consists of the language that is used by doctors, nurses, other medical professionals, patients, bureaucrats and others, that describes diagnoses, illnesses and forms of treatment, and that is employed in documents such as journals, prescriptions, release forms, textbooks, and magazine articles (Foucault 1970; Foucault 1973a).

A central hypothesis of discourse analysis is that language both shapes and is shaped by social structures, roles and interactions. Through genre conventions, legal and institutional constraints and psychological expectations, medical discourse shapes the production of individual discourse objects and discourse participants described above, while

simultaneously being a product *of* such discourse objects, discourse participants and their interactions. This interactional aspect is a crucial part of the explanation for changes in discourse over time. Medical discourse today differs from medical discourse at any other time; while a work on phrenology may have belonged to medical discourse in the 19th century (Gall and Lewis 1835) or to criminological discourse in the early 20th (Gould 1981; Lombroso, Horton, and Rich 2004), it currently belongs to neither except in a strictly historical sense. Similarly, much of contemporary debate about so-called alternative medicine, including the certification standards for and regulation of its practitioners, can be viewed as a debate about the limits and scope of medical discourse, in particular its standards and techniques for self-regulation (Goldacre 2008).

The ebb and flow of key words and phrases, textual structures and communicative conventions within and across the changing borders of discourses is of particular interest in the case of disability, due partly to the long and highly variable history discussed in the previous section. For example: As disability has come to be defined less in the theological and moral terms that prevailed until the Enlightenment (Stiker 1999 [1982]:ch.1-3), and more in technological and bureaucratic terms (i.e., medical intervention, rehabilitation and employment), so too other changes have occurred in the physical and social circumstances that shape the lives of disabled people. The causes of such changes cannot of course be restricted to discourse; rather, discourse is a highly visible indicator of change in a variety of other, less easily observable phenomena – including the way in which people and institutions understand disability. Discourse analysis can identify change in an externally observable phenomenon, that is, spoken and written language; it thus seeks to describe the way in which patterns of thought and comprehension are altered.

This ambition entails a pair of epistemological problems: (1) there is no trans-historical or trans-cultural concept of disability with which to correlate disability discourse, and (2) even the nature and prevalence of bodily impairments that pre-exist discourse change greatly over time. Changes in curative techniques, nutrition, public health and health and safety regulations, among many other things, mean that samples of the

Norwegian population from 1850 and 2000 would display radically different occurrences of illnesses and impairments. Over the same period, as medical technology has become more advanced and refined, diagnostic categories have changed and multiplied. The discourse regime that governs disability in the Western world today is very much a product of its time (Tremain 2005), but so are the bodies that it governs.

Under these conditions, it may legitimately be asked whether the study object of disability discourse can be considered sufficiently stable for it to be discussed outside of a very limited historical period. However, the very same radical changes over time arguably support the case *for* discourse analysis, because such an approach will be aware of its limitations. Research on disability discourse, as on any form of discourse, must begin with the precept that its object is malleable before, during and after the research process. By contrast, if a researcher presupposes that identical understandings of "disability" or "disabled people" can be found in different historical or cultural settings, or even in different institutions in the same historical-cultural setting, significant or even crucial nuances will be overlooked. Discourse analysis provides a strategy for identifying telling differences.

The origins of discourse analysis lie in different research traditions that are concerned with the constitutive function of language. Besides being influenced by both the linguistic and the sociological sub-disciplines that explore language's role in constructing social reality in both institutional and informal settings (Gumperz 1982; Gumperz and Hymes 1986; Sacks and Jefferson 1992; Thornborrow 2002), discourse analysis has roots both in the philosophy of language and in social philosophy / social thought. The philosophical origins of discourse analysis are usually traced to the late works of Ludwig Wittgenstein (1953), the work of J.L. Austin (1962; 2000), and of John Searle (1969; 1979), in that this tradition supports the notion that meaning derives from social convention, whether implicitly or explicitly. The origins in social thought lie with the early work of Michel Foucault (1970; 1973a; 1973b; 1977), which delineates the historically contingent nature of many central institutions, both physical

and social, of the modern world – and presents the discourse which constitutes them.

Disability is, at the beginning of the 21st century, intimately tied to constitutive discourse: As it has become a substantial and relevant topic whenever human rights are discussed, so a new language game is set up for play. Disabled people are no longer understood to be exclusive *disabled by their bodies*, but also by social arrangements, political practices and economic constraints that constitute human rights violations. Alternatively (Oliver 1990; UPIAS 1976), one might compare disablement of impaired individuals with socio-economic oppression. This neo-Marxist view, which has been influential in disability studies (and to which I return in the following chapter), dovetails with another antecedent to discourse analysis: the Frankfurt School of sociology and social thought, of which Theodor Adorno and Max Horkheimer were the most prominent exponents (see Adorno and Horkheimer 1972). The Frankfurt School project of describing and analyzing *ideology* in its socially productive capacity is highly relevant to disability discourse, both because the concept of disability is entwined with a specific social role and because that role is usually one of social disadvantage. The Frankfurt School is strongly identified with the notion of *critique*, understood as the ongoing attempt to explain and counteract systems of domination and dependence, and so has provided much of the framework for discussing the power relations that, partly through language, continue to shape hierarchical or asymmetric social relations in modern society.

Discourse analysis, critique, and activist research

The notion of critique is central to both disability studies and discourse analysis. This centrality is particularly clear in the latter case, as is demonstrated by the prevalence of the sub-disciplinary label *critical discourse analysis* (CDA), and its antecedent *critical linguistics*. Critical linguistics emerged in the UK over the course of the 1970s and 1980s, as studies were undertaken to examine how power relations are reproduced by means of language (Fowler, Kress, and Hodge 1979; Kress and Hodge

1979). Critical discourse analysis, as remembered by one of its key practitioners, emerged

> in the early 1990s, following a small symposium in Amsterdam in January 1991. By chance and through the support of the University of Amsterdam, Teun van Dijk, Norman Fairclough, Gunther Kress, Theo van Leeuwen and Ruth Wodak spent two days together, and had the wonderful opportunity to discuss theories and methods of discourse analysis and specifically CDA. […] Of course, this start of the CDA network is also marked by the launch of van Dijk's journal *Discourse and Society* (1990) as well as through several books, like *Language and Power* by Norman Fairclough (1989), *Language, Power and Ideology* by Ruth Wodak (1989) or Teun van Dijk's first book on racism, *Prejudice in Discourse* (1984). (Wodak and Meyer 2001:4)

Since then, though not the only form of discourse analysis (see Scollon and Scollon 2004), CDA has become a dominant paradigm. This development is not entirely unproblematic. Although many different kinds of language have been analyzed within the CDA framework, the emphasis has largely been placed on text and talk produced in the public sphere or by public institutions, including but not limited to news stories, parliamentary debates, political party programs, and police interviews. Moreover, as is made particularly clear in Normain Fairclough's *Language and Power*, CDA is a framework with an agenda. Its practitioners often deploy it as a weapon with which to combat the abuse of power. This goal is widespread in discourse analysis, and, not incidentally, much of disability studies as well. This thesis is oriented towards areas of disability discourse where the two forms of scholarly practice coincide, with regard to both interests and intentions. It is meant to be a critique of (1) what this authors considers false dichotomies that are central to certain antagonistic kinds of language use in the disability field (see Article III & IV), and of (2) the notion that one kind of (social, rights-based) disability discourse can be efficacious without drawing on another (medically inflected) kind of discourse (see Article I & II).

In this context, it should be noted that the CDA *label* somewhat underplays the integrality of critique – by suggesting a distinction from non-critical or regular discourse analysis. In the thesis's articles I through IV,

which were written in that order, CDA is gradually replaced simply by "discourse analysis". This development reflects a change in attitude on the author's behalf; not towards the goals of and grounds for critical discourse analysis, but towards the place of critique in social and linguistic research. Like any discipline of the social sciences or the humanities, discourse analysis must *necessarily* be a critical, reflexive form of scholarly practice. If understood to be the analysis of various instances of language use, discourse analysis can never truly ignore social context, and so must establish some form of critical stance or risk accepting prejudices tied to language users and forms of use. The strategic usefulness of the CDA label should not be disparaged, but any attempt to distinguish between critical discourse analysis and "plain" discourse analysis will likely be self-defeating. Since discourse analysis can never be entirely detached from sociopolitical context, any description of concepts such as disability, gender, ethnicity or poverty must necessarily involve other concepts, such as (respectively) impairment, sex, race and wealth – and the different linguistic surroundings in which such concepts are used.

This description cannot be complete without reference to language use and language users, or to the society in which the usage takes place – and it cannot be wholly value-neutral or objective. In this context, critique is simply the continuous examination of the assumptions of and background to any particular act of analysis, and serves as a strategy for preserving the researcher's integrity and methodological honesty.

Additionally, discourse analysis derives its purpose from the fact of social inequality and the goal of social justice. There are many branches of linguistics that aspire to value-neutral descriptions of the structures and functions of language, but there is little or no purpose to a description of social structures and relationships that does not also have something to say about the impact of such structures and relationships on people's lives.

There is a second way to read, or perhaps misread, the "critical" part of CDA, one which is made salient by the continuing attention paid to official or powerful texts and talk – to the discourse of parliaments, the police, and the tabloid press. The goal of identifying and countering the forms of language use that abet or facilitate the abuse of power makes

such discourse an enticing analytical target. However, the tendency for CD analyses to focus on the negative, whether racism (van Dijk 1984; Wodak and van Dijk 2000), right-wing extremism (Wodak and Pelinka 2002), particular aspects of Thatcherism or neoliberalism (Fairclough 1992; 2001 [1989]; Fairclough, Cortese, and Ardizzone 2007), or media excesses (Fairclough 1995), has contributed to the perception within CDA that it is a discipline that primarily criticizes undesirable phenomena.

A longstanding tradition exists to this sense of "critical"; the conclusions of critical linguistics of the late 1970s and early 1980s often depend on close reading of small samples of text, in which particular attention is paid to the use of the passive voice, to the absence of clear agency, and to other features of syntax and semantics that intentionally or unintentionally obscure the role of a person, institution or state in a particular event. This effect, usually termed "mystification", is the classical example of the abuse of power through language, as in Norman Fairclough's analysis of a newspaper notice where the responsibility for unsheeted lorries from a quarry, shedding stones while being driven through a village, is left ambiguous:

> The power being exercised here is the power to disguise power, i.e., to disguise the power of quarry owners and their ilk to behave antisocially with impunity. […] It is a form of hidden power, for the favoured interpretations and wordings are those of the power holder in ours [sic] society, though they appear to be just those of the newspaper. (Fairclough 2001 [1989]:43)

This particular example of CDA has already been criticized by Kieran O'Halloran (2003:76-77) for not taking into account the inference-generating power of phrases such as "unsheeted lorries" and "quarry" – lorries have drivers, quarries have owners. Another and more general point is that the news item, taken as a genre, is a particularly apt target for critical readings because it is ostensibly neutral and objective, qualities that are impossible to achieve in fact.[2]

[2] I have discussed this more extensively in my master's thesis (see Grue, Jan. 2008. *Film as Commodity: A Critical Discourse Analysis of Newspaper Film Reviews*: VDM Verlag.

If the "critical" part of CDA is taken as an injunction to *criticize someone* rather than to provide a critical interpretation, then the analysis will be lacking – a point made previously by Henry Widdowson (2004). CD analysts who direct their aim toward text or talk with the explicit or implicit aim of finding something blameworthy run a double risk – that of reproducing their own ideological biases, and that of ignoring one of the essential functions of true critique: the presentation of alternatives. The goal of critical-reflexive language analysis is not to produce a definitive, external account of a phenomenon, whether positive or negative. It is simultaneously to provide an account of and to enter into a network of discourse objects, and the discourse objects in question cannot be selected on their potential for demolishment.

In the case of this thesis, the author's slightly precarious position at the intersection of discourse analysis and disability studies is relevant to these considerations. Since the primary material is drawn from a single NGO, the discourse objects produced by that NGO have been situated in context as far as possible. The organization in question is a political force in Norway, and so could easily be criticized or lauded, depending on one's political position. The purpose of this thesis, however, has been to analyze the discourse of that NGO in order to draw more general inferences about the state of disability discourse, and ultimately about disability.

Plenty of legitimate targets exist for harsh criticism in disability discourse. Discriminatory practices and statements are, unfortunately, everywhere. Such targets can be identified and attacked much more swiftly, and probably more effectively, by activists than by researchers. The role of research, in this context, is to provide a longer view – one which is potentially useful to activists, and which may well be influenced by the activist mindset, but is not beholden to activism.

Interdisciplinarity

This discussion of discourse analysis and the role of critique must conclude with a note on interdisciplinarity. Three of the articles included have been published or accepted for publication in journals that are primarily read by discourse analysts, while the fourth was published in a journal of disability

research. This division represents fairly accurately the balance of the thesis as a whole – it is about disability, but is a work of language studies first and of disability studies second.

Disability studies is a relatively small field of both the humanities and the social sciences; it has nevertheless developed a distinct identity and a correspondingly distinct set of publishing criteria. Since disability is often perceived as a marginal topic, a tendency exists for disability research, at least in the English-speaking world, to be published in journals that cater mainly to practitioners of disability studies. This is not necessarily a desirable state of affairs, since many of the problems pointed out by disability studies research cannot be completely understood, let alone solved, without the participation of city planners, architects, social scientists, jurists, and numerous other groups. While it is valuable and necessary to have an arena in which theoretical and discipline-specific issues of disability studies can be discussed in depth, it is equally necessary to engage in interdisciplinary publication of disability research. This is itself an act of critique; disability, when introduced as a variable in the debates of other disciplines, tends to force the re-evaluation of many norms and assumptions.

Interdisciplinarity usually comes with methodological problems. Additionally, no canonical method exists for the practice of either disability studies or discourse analysis. Disability studies is held together primarily by its subject matter; it is practiced by scholars whose specialties range from medical anthropology to comparative literature. Discourse analysis has a large and eclectic set of methods and approaches, not all of which can be used simultaneously. Research that involves both discourse analysis and disability studies runs the risk of speaking into the void.

Faced with these two methodological problems, which are also problems of audience and relevance, the author has attempted to focus on two academic goals. The first is to bring disability to the attention of discourse analysts and other researchers on language, and to demonstrate that the topic is sufficiently relevant, complex and engaging to warrant further research. The second is to demonstrate, for disability researchers, the usefulness of discourse analysis as an outside perspective and a meta-

language for discussing the purpose and direction of disability studies. The methodological approach, which will be more extensively discussed in the following sections, was based on these two academic goals.

Of course, there are other goals too – goals of a political nature. Among the results that emerge from this thesis is the notion that the current understanding disability has, in many social arenas, moved beyond the strictures that are inherent in the dichotomy of social and medical models. This has clear implications both for socially committed academics and for activists with an interest in social theory, as well as how language can most usefully be employed in legislative documents.

The author is not an active member of the disability rights movement, beyond certain commitments as a researcher and as a strong believer in communicating the results of research to as wide an audience as possible. However, being a wheelchair user means being a fellow traveler with that movement. The author holds a personal stake in disability rights being established in as many areas of society, and being as strongly defended, as possible. This investment cannot be legitimately excluded from this introduction. The desire for the disability rights movement to succeed lies behind much of what is written here, for much the same reasons that medical researchers and pharmacologists want their treatments to be work and their drugs to be effective.

This fact does not relieve the author of any theoretical, methodological or empirical responsibilities; it is simply an integral part of the research process. The following section contains additional details about that process and its challenges, and the recounting of which would be remiss without this note about the status of discourse analysis as a socially committed form of research which must be situated, transparent, and explicit about its purposes and goals.

Methodology: Discourse analysis, rhetoric, prose studies, and the case study approach

Given that discourse analysis is a form of scholarly practice, has unsurprisingly been host to a variety of methodologies. The five-volume anthology *Discourse Studies* (van Dijk 2007) includes 79 articles, with

examples of close reading, conversation analysis, metaphor analysis, argumentation analysis, and analyses of syntactic, semantic, and pragmatic features – among many other methods of language study. There is no dearth of useful tools for the discourse analyst, but the freedom of choice is accompanied by a considerable responsibility for choosing tools that are apt, relevant, and compatible.

That dilemma – freedom and responsibility – forms the background of this thesis. The author's choice of NGO and state documents as primary sources and objects of analysis was partly influenced by a grounding in the Scandinavian tradition of *prose studies* (cf. Berge 2001; Ledin 2005; Tønnesson 2002; 2008), which approaches non-fiction prose, particularly that produced by socially significant institutions rather than individual authors, with a number of investigative tools from linguistics and rhetoric alike. The drive towards methodological plurality also meant, in this case, that some works of rhetoric with a strong interdisciplinary orientation were taken as an inspiration, whether the interdisciplinarity manifested through feminist scholarship (Glenn 1997; 2004) or through economics (McCloskey 1985). Rhetoric has, throughout much of its long history, been at its most useful when directed towards the praxis and conventions of particular social spheres; Aristotle's topics are as much a guide to social arrangements as to elocutionary efficacy.

Any study that aims at a description of social phenomena by way of analyzing texts is faced with a formidable problem of corpus selection. The articles that constitute this thesis concern four case studies; they are pinhole views of panoramas.

The author's initial reading in disability studies, as well as personal experience as a wheelchair user and a very limited amount of organizational experience, suggested the strategy for situating the research questions. The thesis's overall model is one of contrast and comparisons, especially between the social and the medical models (even if the contrast is far less sharp than expected; see Articles I and III). Contrast is also found between official/programmatic and everyday language (see particularly Article I, and NGO professionals' language reproduced in Article III), between overarching ideological conceptions and ground-level pragmatic

adaptations (see Article I), and between ostensibly antithetical research traditions and fields of practice (see Article IV).

The data was selected to fit with this model, based on criteria of a) relevance, b) centrality, and c) representativeness. The strategy was to base the analyses on texts that could be expected to explicate the views of particular institutions or individuals that have influence on politically significant disability discourse, that is, to write primarily about discourse with ripple effects. These selection criteria explain the inclusion of the key policy documents of FFO (see Article I), the anti-discrimination law of 2009 (see Article II), and key texts of academic disability studies (see Article IV). These core sources of data have been supplemented with data that serve a contextualizing function, for example press releases (see Article I) and interviews with agents in the FFO system (see Article III).

The selection criteria have been fundamentally *heuristic*. There is no tagged corpus, and minimal use of quantitative analysis; when quantitative tables have been included, the purpose has been to summarize an essentially qualitative argument. This strategy was chosen largely because the questions under consideration can be answered in the most meaningful way when they are reflected upon and discussed at length. The texts analyzed here are certainly representative (of a particular NGO, see Articles I and III, and of a particular form of legal discourse, see Article II); the analyses strive towards validity according to the standards of argumentation. Nevertheless, the results are, fundamentally speaking, interpretations – a characteristic they share with many results produced within the domain of discourse analysis.

Particular attention has been paid to the presence of certain textual elements – recurring topics and themes – that have been approached under the heading of *topos analysis*. The topos originates in classical rhetoric (cf. Aristotle, Tredennick, and Forster 1960); it is variously the *commonplace* of everyday speech, and the *mental place* from which arguments originate. The topos has been treated as an analytical category for identifying certain perspectives on disability, that is, as a way of identifying discourses in discourse objects. The argumentative or warranting (Toulmin 1958) function of such topoi has been stressed,

because the language that is used to justify claims about disability tells us something about what kinds of disability discourse are currently present and accepted in the society and culture we live in.

The topos has been extensively used by discourse analysts (Wodak and Meyer 2001), but it is primarily a rhetorical concept. The articles in this thesis are primarily works of discourse analysis, and the use of such a rhetorical concept is due both to a) the high degree of compatibility between discourse analysis as a scholarly practice and parts of the analytical vocabulary of rhetoric, and to b) the attention that this vocabulary allows one to pay to matters of audience and intentions. Discourse analyses are sometimes too impersonal in that they ascribe agency *to discourse*, while the rhetorical term "topos" acts as a reminder that the language being analyzed was written by people, for organizations, with purposes in mind. Although the use of rhetorical terminology is restricted in the articles, a rhetorical mindset has certainly informed their writing. The language used by FFO may be productively considered as a response to a particular set of rhetorical challenges; the semantic drift of phrases such as "the social model" from its academic to its NGO context (see Article III) has much to do with the rhetorical differences between academic and NGO prose.

Topoi act as indicators of broader discourse attachments. There can be no incontrovertible *proof* of discourse objects belonging to a particular discourse; there is only overwhelming circumstantial evidence. When making a particular point or orienting its line of argumentation in a particular way, an organization such as FFO (see Article I) implicitly and explicitly signals what it considers to be the current state of discourse on disability in Norway. This practice does not provide us with a basis for indisputable conclusions, but with a reference point, and a point of orientation. Similar points of orientation are provided by the identification of well-known elements of disability theory, i.e., the social model and the medical model, in both interviews (see Article II) and legal texts (see Article III).

The thesis is effectively structured as four partly overlapping case studies. This structure grew partly from planning, partly by accident. A PhD

research project is, almost by definition, a first try. The same research problems, if approached with the benefit of hindsight, could likely have been better addressed through a larger and more clearly defined corpus of texts – based, in part, on the understanding of the disability field that resulted from *this* research process.

Discourse analysis depends to a great deal on the existence of alternative linguistic representations of the world. The research in this thesis would be strengthened by further considerations of radically different views of disability. Disability studies is in the process of becoming a global discipline, partly under the influence of anthropology (Kohrman 2005; Livingston 2005; Petryna 2002). Theoretical constructs such as the social model and the medical model may change a great deal when subjected to the work of cultural contextualization. The mere inclusion of the "Nordic relational model" in a discussion of the social-vs.-medical binary (see the articles, also Shakespeare 2006; Tøssebro 2004) deepens our understanding of the particularly Anglo-American aspects of that binary. Because "[the] Nordic relational model approaches the study of disability with three main assumptions: (1) disability is a person-environment mis/match; (2) disability is situational or contextual; and (3) disability is relative" (Goodley 2010:16), it underscores both the importance of economic oppression in UK disability studies and the essentialist aspects of some American writers on disability and identity. Comparisons with other, non-Western models of disability, could profitably have been made.

Finally, the criticism could be made that the case study approach is susceptible to methodological inconsistency. The best defense is analytical transparency and relevance criteria. More attention has been paid to different empirical phenomena in the analysis of language in 2- or 3-page consultative statements (see Article I:299) than in the examination of a 270-page advisory statement (see Article III:3–5). In the first case, close reading is more appropriate; whereas the second case necessitates keyword searches and thematic summaries.

The goal of providing a credible interpretation of the current state of disability discourse supersedes the otherwise desirable goal of adhering

to a consistent list of analytical procedures, much as the conception of discourse analysis as a form of scholarly practice opens up the possibility for incorporating, e.g., rhetorical concepts whenever relevant to the task at hand. The relevance criteria are, in turn, partly provided by the norms of discourse analysis as defined by the scholarly community, partly by the features and characteristics of the subject matter. These will be discussed in the following section.

Subject matter: The emerging field of disability studies

The history of disability has been described as a hidden history, waiting to be uncovered. This is not to say that disability has not been extensively investigated, but rather that such investigations have been shaped by the agendas of a variety of disciplines, and that the results have been kept atomized and spread out across academe. The historian Paul Longmore has pointed out the negative consequences of this state of affairs:

> [Disability] is a major category of modern social organization and policy formulation. In its socioeconomic, ethical, and policy significance, it is comparable to class, gender, and race or ethnicity. The problem, then, is not that the academy neglects disability, but rather the ways in which this subject is addressed. The danger is not that we will ignore disability, but that we will reach intellectual, socio-cultural, ethical, political, and policy conclusions about disabled people without examining the ignorance, fear, and prejudice that deeply influence our thinking (Longmore 2003:3).

Longmore's point is about the status of and need for disability as an analytical category that cannot be reduced to bodily impairment, and that cannot be studied by the health sciences or sociology alone. In effect, the need for *disability studies* as a distinct discipline is both an archaeological and a genealogical need.

I use these terms in their Foucauldian senses, where *archaeology* is the study of the truth conditions and regulating discourses of certain societies at certain times, and *genealogy* is the study of the coming into being of such conditions and discourses (Foucault 2002). The need for an archaeology of disability is perhaps the more obvious one, because it is well known that disability has usually been found at the margins of society – conflated with poverty, vagrancy and other forms of marginalization. To

write about disability as such is to write about people who, historically, do not get to have their stories told; the act of naming and classification holds power (Bowker and Star 1999). The possibility for critique rests partly in the act of recognizing and discussing disability as a distinct phenomenon – as it does with other phenomena, e.g., madness (Foucault 1973b).

The need for a genealogy of disability is due to the fact that when disabled people *have* been the explicit subjects of discourse, this has, in modern times, often been in the context of institutions of segregation and control, purpose-built for both voluntary and forcible normalization (Gleeson 1999; Oliver 1990; Stiker 1999 [1982]). A politically significant disability movement emerged only a few decades ago, and the social consequences of this emergence, though overwhelmingly positive, are not yet clearly visible or fully understood. The same goes for future developments. This section is intended to provide some historical background for the complex connotations the word "disability" currently holds, and some reasons why language about disability is highly contested.

There have, of course, always existed people who would have been identified as "disabled" in modern society. What is of specifically modern provenance is for the meaning of this identification to be predicated on deviation from a biophysical standard, that is, from statistically determined normality. According to Henri-Jacques Stiker's (1999 [1982]) seminal *A History of Disability*, the pre-modern discourse on disability can be understood chiefly on *theological* and *moral* terms.[3]

Modern discourses of disability are intimately entwined with medicine and the state. Over the course of the 19th century, as medicine grew in institutional size and scientific ambition (Foucault 1973a), and data on the health of citizens, structured by the emerging discipline of statistics, established a strong conception of biophysical *normality* (Grue, Lars and Heiberg 2006). It is within this historical framework that disability began to be conceived as negative deviation from statistical norms, i.e., as *abnormality*. With the proliferation of new curative techniques and the expanding scope of state activity and responsibilities, disability was

[3] It should be noted that Stiker limits his discussion to Greco-Roman, Judeo-Christian, and later Western European, particularly French, history.

principally understood in two ways: 1) as the marker of an individual's legitimate inability to support him or herself in the labor market (Stone 1984), and 2) as the marker of that individual's status as an obligatory object of rehabilitation efforts (Oliver 1990). This understanding evolved semi-independently in most Western European nations and in the United States, and still forms the underpinning of much of disability discourse.

Disability is thus a marker of both stigma and privilege in the modern world. The needs-based economy to which a state-sanctioned status of disability provides access in many countries is obviously preferable to penury, but the accompanying regimes of institutionalization and control, not to mention social devaluation and a general lack of autonomy, have for many people constituted a degree of oppression that is unknown outside the penal system. Thus, when disabled people themselves have attempted to establish counter-discourses, much of the impetus and strategy have been similar to those of social liberation movements centered on identity categories such as gender, sexual orientation, or ethnicity; the struggle against oppression, repression and discrimination has provided a shared focal point for people with very different impairments.

Both in the United States and in Europe, sporadic pre-war efforts towards an autonomous disability movement (Longmore 2003:41-102) are overshadowed by the successes from 1970s onwards, in terms of both representation and legislation. These developments coincide to a great extent with the maturation of the welfare state. The rights of disabled individuals to self-determination, education, housing, employment, etc., have been fought for within the context of general welfare state goals, eventually – in many countries – resulting in disability rights omnibus bills. The first and best known of these, the Americans with Disabilities Act (United States 1990), had many flaws (Colker 2005; Krieger 2003), but was universally recognized as establishing disability as a legal category whose relevance stretches across most if not all life areas.

The growth of the disability movement, the introduction of disability rights legislation, and the flowering of disability studies as an academic discipline, are co-occurring and mutually influential

developments. Fields of practice have overlapped considerably; many key activists in the disability movement had strong ties to academe or became professional researchers later in their careers. For this reason, disability studies has been, from the start, both an interesting and a problematic part of academe. The pressing social need for useful research on disability has provided a valuable impetus, but the multiple unresolved issues of activist research in general have proved relevant to disability studies as well. Within the field, the search for an epistemological framework, strong theories and a clear disciplinary self-understanding continues.

Although this thesis does not focus only on the status of disability studies as an academic discipline, the topic has proved highly relevant to its overall concerns. In particular, the investigations into the social model / medical model dichotomy led more or less directly to this set of problems. The social model is now seen by many researchers and writers as providing weaker material for a primary theory of disability than was once hoped for (see in particular Shakespeare 2006). According to Google Scholar, however, it remains the most widely published alternative – and its critics are hampered by their diversity, that is, their lack of a single strong alternative. The medical model is not an alternative, and is hardly ever discussed by disability studies scholars unless in negative terms. Any other model, including the (US) minority or cultural models, comes a distant third in the literature.

Nevertheless, disability research is flourishing as a polyvalent enterprise, informed by any number of disciplines. Additionally, and perhaps more importantly, many concerns, perspectives and goals that originated with the social model are shared by people and institutions that remain expressly hostile to the ideological connotations of the social model itself. It may well be possible to save the social model, perhaps even under that name, but it will be necessary to greatly adapt and adjust it. And after two decades of debate over its merits and efficacy, it would appear that a major overhaul of the underpinnings of disability studies is being undertaken – both out of necessity and out of ambition:

> Roughly speaking, it appears that while disability studies research has produced a highly useful reconceptualising of disability as a social phenomenon, and has

> produced useful empirical analyses, it lacks essential dimensions of theoretical scrutiny necessary to do justice to the complexity of the phenomenon (Kristiansen, Vehmas, and Shakespeare 2009:1).

> Now we confront the second-wave of disability studies. In this era, the foundational "truths" come under new scrutiny. […] We can see this questioning already occurring in the areas of identity formation, the differences (rather than the similarities) between models (notably those of the United Kingdom and the United States), questions about the relation of theory to praxis, and the role of the intellectual vis à vis the activist (Davis 2006:xiii).

> My objective here is […] to theorize the emerging field of disability studies by putting its core issues into contact with signal thinkers in the adjacent fields of cultural studies, literary theory, queer theory, gender studies, and critical race studies (Siebers 2008:1).

The retooling of disability studies and its theoretical apparatus, then, has much to do with the re-analysis of basic concepts and accepted truths. This retooling is a necessary project for any field that does not enjoy much of a consensus about many of its basic terms. Of course, a heightened degree of awareness about the power of definitions has been with disability studies for a long time:

> Specific criticisms of the WHO scheme [of the early 1980s] have focused on the fact that it remains close to medical classifications of disease – disability – handicap. In so doing it conserves the notion of impairment as abnormality in function, disability as not being able to perform an activity considered normal for a human being and handicap as the inability to perform a social role. This reification of the idea of normality ignores the issue of what normality actually is, but even if the idea of normality is conceded, the failure to recognise the situational and cultural relativity of normality is a serious omission in an international scheme (Oliver 1990:4).

This awareness means that disagreements between disability studies scholars about terminology are often grounded in basic political or philosophical disagreements. For example, Mike Oliver in his seminal *The Politics of Disablement*, quoted above, adopts the following definitions of "impairment" and "disability", which were originally proposed by the activists of the Union of Physically Handicapped Against Segregation (UPIAS

1976). Those definitions, quoted below, have proved very contentious over the years:

> *Impairment* lacking part or all of a limb, or having a defective limb, organism or mechanism of the body.
>
> *Disability* the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from the mainstream of social activities (quoted from Oliver 1990:11).

A full review of the debate over this early version of the social model is beyond the scope of this introduction. The topic is addressed more extensively in the articles, particularly Article I. Here, two well-known alternative approaches to the definition dilemma will be cited:

> **A social relational definition of disability**
> Disability is a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional well-being (Thomas 1999:60).
> [D]isability is always an interaction between individual and structural factors. […] The experience of a disabled person results from the relationship between factors intrinsic to the individual, and extrinsic factors arising from the wider context in which she finds herself (Shakespeare 2006:55).

These criticisms of the social model are directed toward its reductive aspect; as such, they are representative of criticism by the many scholars who have found it useful as a point of departure, but see a need for revision, expansion and theoretical development. From the time of Mike Oliver writing in 1990, through Carol Thomas in 1999, to Tom Shakespeare in 2006, none of the proposed alternatives to the social model have been broadly adopted. Nevertheless, criticisms from many parties have contributed to a softening of social model orthodoxies, and to a research culture that is, on the whole, more congenial to interdisciplinarity.

The really existing social model of today, as it is interpreted and used by scholars who see disability studies as related to cultural studies, identity theory or sociology, exhibits a *rhizomatic structure*. The term, borrowed from Deleuze and Guattari (1987), is a useful visual metaphor. A rhizome is the stem of a plant, one that usually grows horizontally,

underground. It branches out in many directions, and unlike, say, a tree, it lacks a central or primary root. (See also Goodley 2007 for more on the rhizomatic approach.)The social model retains its early definitions, of course, but as Tom Shakespeare has pointed out, even the UPIAS definition cited above does not define the Year Zero of the disability movement – its publication was one important early achievement among several others.

Another useful metaphor for the current state of the social model is that of the *palimpsest* – a manuscript, the text(s) of which has been repeatedly erased and overwritten. The social model has been criticized, again and again, but many if not most of the disability studies scholars, and indeed activists who know of it, at least when compared to scholars and activists in the humanities and social sciences in general, are still on the same page (or palimpsest). This dynamic is discussed at greater length in Article IV.

This view of the history of disability studies as diversification, interdisciplinary expansion, and theoretical recalibration should recall the previous discussion of discourse analysis and rhetoric. Very likely, disability studies is a fundamentally conflicted discipline because it shares with both rhetoric and discourse analysis its status as an explicitly critical discipline. What is the role, then, of critique in disability studies?

Both feminist and ethnic-minority cultural studies have framed much of their critical effort in terms of exposure – whether of oppression or of the hidden and/or suppressed role of women and minorities in the production of great literature, and the corresponding presence of, say, African ancestry in prototypically white European cultural figures. Both of these goals apply to disability studies, but in somewhat different ways. As Sharon Snyder and David Mitchell (2000; 2006) have shown, disability is largely already present in the cultural-historical matrix. The matter at hand is not the discovery of a canon of forgotten disabled characters, but rather the treatment and analysis of the multitude of historically recognized phenomena, including aesthetic difference as well as physical and mental impairment, that intersect with the modern category of disability. We have known for a long time that the Shakespearean Richard III is a villainous hunchback; we discovered only relatively recently that the historical

Richard was probably not significantly impaired (Driver and Ray 2009:27; Rhodes 1977; Tulloch 2009). The relevant questions for disability studies are: (1) what sort of effect(s) was Shakespeare trying to produce in his audience by providing his character with such an impairment – by disabling him? and (2) what does Shakespeare's choices tell us about his, and our, society and culture?

The function of critique in disability studies[4] is primarily to provide a corrective to the way in which disability is generally understood by society, thus countering the ways in which society *produces* disability. Any such function depends, however, on a continuous re-evaluation of the way in which disability studies itself understands disability (also the topic of Article IV) – because disability studies is a *part of* the society in which disability is produced. Hence, criticism is self-criticism.

To return to the example of cultural-historical analysis: Any exploration of the role of features and phenomena that are currently linked to the category of disability in earlier epochs and different cultural contexts cannot be honestly undertaken without simultaneously critiquing the same category as it currently stands. To claim that a historical figure or literary character is disabled, be it Alexander Pope or Captain Ahab (and as opposed to "crippled" or "maimed"), makes it necessary to interrogate the modern role of the disabled person and the discourse that makes such a role socially, politically and economically real.

Critique is a double operation. To explain the narrative function and ideological power of a stereotypical literary cripple, a Tiny Tim or a Pollyanna, is to do (at least) two things: (1) to discuss their influence on the current role of the disabled person, and (2) to analyze the way in which our current understanding of disabled identity informs our interpretation of 19th century literature. A form of disability studies that employs a simplistic notion of critique, directed only towards medicalization, for example, will

[4] The term "critical disability studies" is not adopted, though it has been put to good use (and was, to the best of the author's knowledge, introduced) by Dan Goodley (2007). The reasons for this choice are fundamentally the same as those that were cited with respect to critical discourse analysis.

not be sufficient – because medical knowledge is necessary and useful, given the right context and framework (see Articles I and II).

In the NGO field in Norway, too, critically informed disability studies cannot take an a priori negative view of medical discourse. Medical knowledge and medical explanatory mechanisms remain crucial to a comprehensive understanding of disability; it is necessary, for example, to understand the different social contexts in which medical knowledge is put to use (see Article I), and to understand the different agents that employ medical knowledge and the purposes for which they employ it (see Articles I and III). Medical discourse is necessary even to the most ardent advocate of the social model, because it is the only form of discourse that adequately represents certain parts of social reality.

This acceptance of the need for medical or even clinical language does not entail an uncritical position. A continuing and wholly legitimate complaint about medical discourse is that it construes disability as a uniquely personal tragedy due to bodily dysfunction (see particularly Oliver 1990). Medical knowledge becomes both an explanatory mechanism and a prescriptive template; diagnosis X requires treatment Y, and the life situation of any individual who has been diagnosed with X can be traced back to causes that are primarily and essentially within the domain of X.

That is *one* trajectory, but it is perfectly possible to imagine another trajectory, founded on a critical approach to the institutional framework that manages the consequences of diagnosis X. One can imagine a society in which people with diagnosis X are compelled to submit both to interventions defined by the horizon of medical knowledge, such as treatment regimes and surgical interventions, and to institutionalization. It is equally possible to imagine a society in which the diagnosis of X in a sufficient proportion of the population triggers changes in institutions that lie far beyond the medical ken, ranging from schools through workplaces to public spaces. In most societies in which medical diagnosis plays a central role in disability discourse, both scenarios likely play out continuously and simultaneously. Part of the critical mission of disability studies is to understand the conditions under which such scenarios play out.

Critique should be based on realistic assessments of intentions. It is a fact of Norwegian society that most NGOs in the disability field are organized according to the divisions and criteria of medical knowledge, even in the cases where the NGOs themselves explicitly reject the medical model. Does this mean that they are acting in bad faith, unconsciously reproducing medical-model ideology while claiming to embrace the social model? Does it mean that the medical model, through the multiplication of single-diagnosis NGOs, through the ever-refining techniques of diagnosis, is becoming increasingly hegemonic, that it is colonizing a field that should by rights be organized according to social model precepts? It seems unlikely, because the NGOs are simultaneously expanding their political agenda to new areas of society, explaining exactly how the diagnostic group they represent wish for society to be altered – frequently in ways that have very little to do with medical knowledge proper.

Different discourses of disability appeal to different constellations of people, and are grounded in different areas of experience. The social model is a creation of academic and activist circles, and it proliferates in academic, activist and to some extent policy circles. By focusing on structural and systemic causes of discrimination, on the large-scale construction of disability, it left itself open to criticism from feminist and phenomenologically informed reassertions of the importance of individual bodies. This refining critique, however, tends to be contained within the same fields – activism and academe – as the social model is.

In other fields, the discussion easily devolves to a matter of social model versus medical model – not least because advocates of the social model have promoted this dichotomy. One unintended outcome of the dichotomous strategy, however, is that the experiential domain that is underexplored by the social model – having an impaired body – becomes, by default, assigned to medical-model explanations.

The power structures of medical knowledge are historically real, and continue to exert enormous influence. But the ‘‘medical model’’ as such, not to mention ‘‘personal tragedy theory’’ is an explanatory concept developed within the framework of the social model. Numerous examples can be found of doctors, social workers, philanthropists, etc. who champion

medical intervention as a way to solve problems of disability, but it is significantly harder to find lines of argument that reduce disability wholly to a matter of medicine. In some cases, medical-model discourse is contained within social-model discourse, as is arguably the case with FFO (see Article I and III).

Still, medical diagnoses are a continuing and overwhelmingly important part of the lives of many disabled people, for the simple reason that health matters as much to the disabled as to the non-disabled, and that bodily impairments, though they need not have direct impact on health, often have just that. The line between impairment and chronic illness is so blurry in places as to be invisible, a fact that is acknowledged by the continuous referral in disability discourse to both phenomena as co-equal in creating a basis for and legitimization of social change. Moreover, even without taking into consideration the effects on health, it is extremely difficult to talk about impairments with any precision without the use of a medico-diagnostic vocabulary.

Medicine does not have a monopoly on talking about the body, but it is uniquely positioned to describe the body in inter-subjectively valid terms. It is therefore very dangerous to conflate the medical model with medical language in general, or even medical discourse. This conflation, however, is enabled by the alienation of some versions of the social model from such discourse.

This does not have to be the case; in many parts of the rhizome, scholars are adapting the medical discourse to the social model framework. There is no lack of disability research that is both informed by social model perspectives and cognizant of the body's importance (Crow 1996; French and Corker 1999; Kohrman 2005; Paterson and Hughes 1999; Shakespeare, Davies, and Gillespie-Sells 1996; Siebers 2008; Thomas 1999; Wendell 1996). But it may be the case that this research has not been sufficiently widely disseminated, and that the social model, in turn, has its impact weakened outside of academe.

I now come to my final point about the role of critique in disability studies. The reception of academic theory outside the academic field is a complicated matter. The narrow interpretation of the social model that is in

play in part of the Norwegian NGO field (see Article III) may simply be a case of disseminated knowledge lagging behind developments in its academic field of origin. It may also, however, be a function of the exigencies of developing viable policy. The NGO field is both closely matched to and dependent on the actions of the state (see Article II). The embedding of diagnostic categories in state bureaucracies forms a basis for broad welfare initiatives as well as for almost every kind of individual accommodation. This phenomenon can alternately be conceived as a reinforcement of the medical model *or* a basis for expanding the conceptual flexibility of the social model.

Disability studies cannot ignore these factors, but must continually reassess itself based on how its ideas, theories and models are received and interpreted by others. Particularly in this regard, disability studies, like discourse analysis and rhetoric, is a discipline in which critique plays a crucial part.

Chapter 3: Analysis and results

This chapter contains brief comments on the research process in general, on each of the articles in particular, and concludes with results and implications.

Analysis

The material for this thesis is language in context, and originates from three kinds of primary sources. The first is *public documents* of various kinds, including laws, bylaws, newsletters and press releases that deal with disability. The second is *transcribed interviews* with non-governmental professionals from disability NGOs. The third is *academic literature* on disability. Texts from this last category also serve as secondary sources, particularly in Article IV.

This double position with regard to the academic literature deserves some explanation: While disability studies is an academic discipline, it is also inhabited largely by people with a past or current commitment to activism. Many texts written for peer-reviewed journals or academic presses are also used in political debates. Therefore, they contribute to the shape of discourses of disability while simultaneously analyzing such discourses. This thesis is no exception; some of its results have already been presented to the NGO community.

The present author's entry into the disability field dates back only to the summer of 2007 and the initial survey of some of the NGO-authored documents that inform this thesis. It took some time to realize that although the same topics were treated in both academic and NGO texts, the vocabulary differed in a way that appeared to hinder dialogue between academics and disability professionals (see Article III). It has therefore remained a priority to maintain throughout the research process a semi-detached view of disability studies literature, to not simply have it provide a theoretical perspective on the issues at hand, but also to consider it an object of analysis.

The material from all three sources was gathered continuously for the first three years of research. Since this thesis is based on articles that have been published over a similarly long period, the research process can

best be described as *cybernetic*, that is, characterized by feedback – in the form of informal reader responses, formal peer reviews, comments on finished articles, etc. – and corresponding adjustments. From an initial article that is chiefly built on the close reading of a particular organization's documents to a final article that deals with the disability field more generally, the scope widened and the thesis's central topic changed correspondingly. The more circumscribed notion of the empirical scope, i.e., the self-perception and role of a single disability organization, was replaced with one that is more expansive, i.e., the way in which disability is currently understood in various contexts.

From a rhetorical viewpoint, it may be noted that this process of expansion is not dissimilar to a common way of structuring argumentative texts, a way that has deep roots in the oratorical tradition. From an initial question that may well be of a general nature, suggested or explicitly posed in the *exordium*, or introduction, the rhetor proceeds to the specifics of *narration*, the description of the problem, and *argumentation*, the main argument, to the general appeals of the *peroration*, or conclusion.

The four years that the author spent in the field is not a very long time, all things considered, but it may be useful to mention one particular development over that period. That development has to do with the current needs of the field, specifically the issues of adversarial debate and theoretical consolidation. An important part of the international disability field, as mentioned previously, is the perceived dichotomy between the social and the medical models. Gradually, through reading the primary and secondary sources, and through conducting analyses, the author has come to see that dichotomy as less relevant and less real than it may once have been, and less meaningful even in retrospect.

Article I sets out the thesis that FFO, the NGO, employs the social and medical models in different contexts, for different purposes. In Article IV, it is suggested that the time is ripe for moving beyond social and medical models entirely, because more can be gained by aligning the medical model's discourse with the social model's goals. An approach to disability studies is suggested that may be less amenable to formal models like those proposed by the Union of Physically Impaired Against

Segregation and Disabled People's International, but more flexible in aligning the everyday experiences of people with a variety of impairments. The goals of social justice and equal opportunity that have become integral to the current understanding of disability are shared across impairments; the trick is to find a way to interpret what they mean in each case.

In addition to the research itself, this development has much to do with thesis being written at Oslo University College's Faculty of Health Sciences, in close proximity to its Master's Program in Rehabilitation, which is attended by professionals from a variety of health sciences, including nurses as well as physical and occupational therapists. This program has demonstrated, for this author at least, that many goals that are closely identified with the social model are shared by rehabilitation professionals and disability rights professionals alike, although they may lack a shared language to make the commonalities apparent. While not explicitly discussed outside some points in Article III, this high degree of commonality supports the case that goals that originated within the framework of the social model can be effectively communicated to society at large, given the right rhetorical approaches and discourse strategies.

Disability research has experienced phenomenal growth and development over the last decades; this thesis has benefited greatly from that fact. Disability is currently being discussed and analyzed from so many perspectives and within so many traditions that, given time, it seems likely to transform many basic assumptions of large parts of the humanities and social sciences. This thesis aims to be a part of that process.

Article I: Grue, J. (2009). "Critical discourse analysis, topoi and mystification: Disability policy documents from a Norwegian NGO." *Discourse Studies* 11(3): 285–308.

Abstract: In disability studies, social and medical explanatory models are seen as being conflicting or mutually exclusive, and as mystifying respectively bodily impairment and the agency of social and environmental factors. This article uses critical discourse analysis (CDA) to discuss the relationship between such models in policy documents produced by The Norwegian Federation of Organizations of Disabled People (FFO). Analysis of key *topoi* in the policy documents shows that they display elements of both social and medical discourse, and that the consequences of medically defined impairments are used as justifications for policy interventions in a framework of social justice. While a strict version of the social model is adopted in general programmatic documents, arguments about specific policy fields conceptualize disability as a property of individuals – traditionally, a medical model framing. Analysis of *topoi* is shown to be a useful tool when CDA is applied to policy texts.

This article was conceived as an overview of the discourse of FFO. The research included a review of the organization's history and its place in the Norwegian disability field, and of an extensive selection of its programmatic and other texts. From this basis, a corpus of primary objects of analysis was selected, with an emphasis on those documents in which the organization explicitly states its definition of disability. The analysis is based on charting the influence of the social and medical models in the organization's discourse, specifically by identifying recurring topoi that serve as anchors for the models.

The initial round of peer reviews affected a number of changes in the text. The number of topics and themes was drastically reduced, the review of the social and medical models was compressed, and several passages on topos theory in the context of formal argumentation and pragmatics were removed.

In retrospect, the analysis should have been based on a more rigorously structured corpus, preferably one that would have included all the documents considered by FFO to be a part of its policy brief – not just the publicly available consultative statements. The peer reviews identified this problem, too, which was somewhat remedied by a more explicit

identification of the corpus as it stood; further efforts could certainly have been made. Although informal interviews were conducted with some of the organization's employees, they should have been made extensive and have been included as part of the material. Even so, the material gathered for this article should be sufficiently extensive to give a fairly accurate portrayal of FFO's pragmatic policy approach. A larger corpus and/or supplementary interviews would have provided more solid grounds for such a portrayal, but I doubt that the overall impression would have been significantly altered.

Article II: Grue, J. (2010). "Is there something wrong with society, or is it just me? Social and medical knowledge in a Norwegian anti-discrimination law." *Scandinavian Journal of Disability Research* 12(3): 165–178.

Abstract: What is the current relationship between the social and medical definitions of disability in Norway? The Norwegian Discrimination and Accessibility Act, which entered into effect on 1 January 2009, frames its overarching goals in terms of human rights and equal opportunity and studiously avoids the use of medico-diagnostic language. Most of the specific provisions of the law are, however, justified as means of compensation for inherent or pre-existing disadvantage due to impairment. In order to be effective, they must engage with medical, impairment-specific knowledge. Social and medical perspectives and explanatory models that are often seen as conflicting or even mutually exclusive instead become intertwined in the spaces of negotiation that are opened by the law. Thus, elements of what has traditionally been termed the *medical model* become integrated in a larger framework that is defined by the goals of the social model.

This is the only article published in a disability studies journal. It contains a brief note on critical discourse analysis, giving the somewhat misleading impression that CDA is a *method*. This note should have been heavily revised, although it should not detract from the methods actually *employed* in the article, including the chart of policy measures arranged according to the dimensions of individual protection / structural change as well as indirect and direct discrimination. A major goal of the article is to evoke the complexity of actual legal measures, as opposed to the analytical purity of theoretical models of disability. Another is to identify the inevitable inclusion of medical categories in *some* area(s) of disability discourse. The chart is intended to convey this linguistic complexity to the reader.

One major issue in particular was pointed out by the anonymous peer reviewer of the *Scandinavian Journal*: This article has a considerable potential for the development of comparative perspectives, although such perspectives would potentially require separate articles or a major expansion in both scope and length. A series of minor issues in a similar vein were pointed out – there is ample room for more in-depth analysis of

further legal texts and documents, including court rulings. Such an analysis must, realistically, be undertaken by an interdisciplinary team of researchers. Disability legislation is a hugely complex field, which deserves the best efforts of both legal and disability studies scholars.

Article III: Grue, J. (2011). "False Dichotomies of Disability Politics: Theory and Practice in the Discourse of Norwegian NGO Professionals." *Language & Politics* 10(1): 109–127.

Abstract: This article discusses the troublesome recontextualization of the medical and social models of disability from the academic to the NGO field. Interviews with professionals from Norwegian disability NGOs show that while they share the political goals of the social model, their attitude towards both the social and the medical model on a general basis is one of considerable skepticism. It is argued that a false dichotomy emerges in NGO discourse when the medical model, which is in academic disability studies a theoretical construction *within* the social model, is instead reinterpreted as a legitimate alternative. In order to escape that dichotomy, it is necessary to develop the social model more extensively in discourse contexts outside the academic field.

The article is structured as an investigation of actually occurring interpretations of the social and medical models as elicited from NGO professionals. As such, it constitutes an empirical corrective to the idealized forms of the models that predominate in academic literature – though a more extensive discussion of this dynamic could be called for.

The interview guide and resulting interviews occasionally give the impression that the author is trying to examine or catch out the interviewees on their knowledge of theoretical models; this was certainly not the intention. The primary object of interest was and is how such models change across time and social space. The intention was not to identify "incorrect" models in NGO discourse, but to see how the NGO field adapts and interprets the notion of models according to its own discursive needs.

As with Articles I and II, a more extensive corpus could well be called for. This was pointed out by the peer reviewers, who also called for a more nuanced approach to the existing models of disability – advice that was heeded in later drafts. The interviewees were selected based mainly on criteria of relevance and representativeness; i.e., they were people who would represent a fair cross-section of the FFO membership organizations. This cross-section could very well have been larger, or the interviews longer

– ideally, a more loosely structured two-hour format, with time for the interviewees to reflect on the role of academic knowledge in their work.

More attention could have been paid, too, to the role of FFO in shaping the discourse of its members and in advancing a pragmatic view of knowledge and politics. This issue of double hermeneutics was pointed out by the peer reviewers – and addressed, to the best of the author's ability.

Article IV: Grue, J. (2011). "Disability and discourse analysis: Some topics and issues." *Discourse & Society* 22(5).

Abstract: Disability is an underexplored topic in discourse analysis. A stronger emphasis on disability issues would be in keeping with the academic principles and political priorities of critical discourse analysis. Simultaneously, a discourse analysis perspective is needed in disability studies. Although that field has produced a considerable amount of discourse-oriented research, it is structured around theoretical models that appear adversarial and incompatible. In practice, many of the incompatibilities dissolve into divisions between different areas of discourse production. A greater awareness of discourse analysis will aid disability studies both in terms of theoretical development and in terms of furthering its goals of social change.

This article is effectively a literature survey with discussion, aimed at introducing disability as a relevant topic for discourse analysts. The argument is made along two complementary lines: a) the work already done in disability studies, and b) the work that *has not* been done in discourse analysis.

Limitations that are inherent in the peer-review format make a truly extensive discussion of disability studies literature unfeasible; in this case, the compressed survey is the only available option. The article as it currently reads was the result of a certain amount of editorial back-and-forth. A section of closer analysis was omitted, and the literature review was made more extensive and substantial. The primary purpose remains what it was in the initial draft: To show that ample common ground exists between discourse analysis and disability studies.

Results and implications

The primary results of the four articles can be summarized as follows: The main Norwegian disability NGO employs an understanding of disability that draws on both the medical and the social models according to its communicative and strategic purposes. Meanwhile, professionals who are active in that NGO share the goals of the social model, while employing a more medically inflected language. This use of both forms of understanding is mirrored by the anti-discrimination law of 2009, which employs the language of the social model when discussing its overall goals, but nevertheless depends on pre-existing medical discourse and practices for those goals to be implemented. In sum, the interaction between and the interdependence of the social and medical models suggest that the prevailing notion of a conflict between the two is inaccurate, and that more nuanced descriptions will be both more accurate and more useful in furthering descriptive precision of disability as a social phenomenon and better communication between language users in the disability field.

The main implications of these results have to do with the status and applicability of disability research, and with interdisciplinary dialogue. The number of potential subjects and topics for future disability research is very high indeed; in Norway alone, possible research projects can be discerned in history (the growth of disability discourse both in state agencies and in civil society), anthropology (disability organizations and communities), political science and law (disability, citizenship, and participatory democracy), information and computer science (the role of technology in heightening and lowering barriers), philosophy and ethics (prenatal diagnostics, personhood) – and of course in the health sciences.

In short, much work is being done, but more work can be envisioned. The ongoing and future projects are too numerous, their subject matter too complex, to belong entirely to disability studies, which remains a small and in some respects an isolated discipline. Conversely, the contribution of disability studies is crucial – it is just that it depends for its efficacy on interaction with other disciplines. The recent emphasis on intersectionality and the growth of crip theory in Anglophone disability

studies (Burch and Joyner 2007; Lombardo 2008; McRuer 2006) identify the need and show the potential for interdisciplinary action and frames of reference. Disability does not exist independent of other social variables such as gender, class and ethnicity, but changes meaning and form, and results in different life outcomes, according to context.

For these reasons, it is necessary to include disability on syllabi across different subjects, and to investigate the traditions of such subjects from a disability studies perspective. This lofty goal will only be achieved piece by piece. This thesis strengthens the connection between discourse analysis and disability studies, a connection that should, and likely will, grow stronger. The overall prospects for disability studies are good: It is expanding in academe, much as accessibility is improving in cities across the globe. It should be remembered, however, that the built environment will not become truly accessible until every architect, city planner and engineer is thoroughly schooled in how to take disability, in all its meanings, into account. Similarly, our society and our culture will not truly understand themselves until disability is an obligatory subject and analytical category across the humanities and social sciences.

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Part II: The articles

Article I: Grue, J. (2009). "Critical discourse analysis, topoi and mystification: Disability policy documents from a Norwegian NGO." *Discourse Studies* 11(3): 285–308.

Article II: Grue, J. (2010). "Is there something wrong with society, or is it just me? Social and medical knowledge in a Norwegian anti-discrimination law." ***Scandinavian Journal of Disability Research*** **12(3): 165–178.**

Article III: Grue, J. (2011). "False Dichotomies of Disability Politics: Theory and Practice in the Discourse of Norwegian NGO Professionals." *Language & Politics* 10(1): 109–127.

False Dichotomies of Disability Politics: Theory and Practice in The Discourse of Norwegian NGO Professionals

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This article discusses the relationship between the *social* and *medical models* of disability and between the academic and NGO communities in that field. Interviews with professionals from Norwegian disability NGOs show that while they share some of the political goals of the social model, they have a somewhat narrow understanding of the model's critical potential. A false dichotomy has emerged in NGO discourse: The medical model, which originated as a negative construct within the social model, is reinterpreted as a legitimate conceptual alternative. This hinders dialogue between academe and the NGO community, and hampers the critical potential of the NGOs. In order to eliminate the dichotomy, it is necessary to develop the social model more extensively in discourse contexts outside the academic field.

Keywords: Disability, discourse, NGOs, academia, social model, medical model, false dichotomies, topoi.

1. Introduction

This article is about the relationship between theory-driven models and praxis-related discourse in the disability field. It is, in part, an attempt to show that one of that field's most salient dichotomies – the choice between a social and a medical model of disability – is far less stable, interesting, and useful than it appears. In

consequence, communication is hampered between some of the most active communities in the field, and the potential for both knowledge production and joint political action is diminished.

There are multiple discourses of disability, with origins in very different academic, political and social traditions. Nevertheless, a mainstay of many debates over the last several decades has been the more or less rigorous distinction between *medical* and *social* conceptualizations of disability and, to a lesser extent, impairment. The medical model, taken as the framing of disability as a phenomenon that can be wholly explained in terms of individual biophysical properties, has frequently appeared as a target of criticism, and much less frequently as an actively defended framework, perspective or position. Put differently, the medical model of disability is a negatively defined entity. While it may be part of the praxis of some health professionals, it is not a serious alternative for theorists who seek to explain the complexities of disability.

Historically, the medical/social distinction grew out of necessity. It appears at its most purely dichotomous in the writings of British sociologists and activists who entered disability politics in the UK during the 1970s (see Barnes, Mercer and Shakespeare 1999; Oliver 1990; 1996; Shakespeare 2006). Their views originate from an analysis of disability as a form of social oppression enacted on people with biological impairments (UPIAS 1976). This early form of the *social model* of disability drew strongly on classical Marxist thought with regard to both language and analysis, complete with dialectical oppositions. The *medical model* (aka. *personal tragedy theory*) is the social model's explanation for how industrial capitalism mystifies the social, political and economic causes of disability: The disabled individual is made responsible for his or her own inability to work, his or her own success or failure on the job market, while no attempt is made to discuss the contingent nature of employers' requirements

for physical ability, the effects of architectural barriers in the workplace, etc.

The medical model, as it emerges from social model literature, offers a productive target for criticism. It is presented as the de facto hegemonic model of disability since, variously, the rise of industrialism and the standardization of biophysical demands on the bodies of wage laborers (Gleeson 1999; Oliver 1990) and the introduction of modern curative techniques or the growth of the welfare state and its rehabilitation regimes (Stiker 1999 [1982]; Stone 1984). To be classified as a disabled person is to be shunted out of the wage economy and into the needs-based economy, and the mechanisms that perpetuate the distinction between the two are deeply embedded in institutional models, professional training and political and economic structures. Therefore, the medical model tends to appear in disability studies writing as a reconstructed form of discourse or as part of a *recovered history* (Longmore 2003). Analyzing the medical model means analyzing some of the least visible aspects of the state throughout its industrial and post-industrial phases, and to explain how charity, welfare and rehabilitation produce a distinct class of disabled citizens out of the raw material of people with impairments.

Conversely, the social model reflects a relatively new way to approach disability, one that is primarily discussed either by its proponents or by critics who speak from a position inside the disability field. This form of discourse is strongly linked to academia, where the British version of the social model engages with other conceptions of disability that reject the medical model and are based in e.g. minority politics (Hahn 1984), cultural studies (Siebers 2008; Snyder and Mitchell 2006), and feminist philosophy (Wendell 1996).

Since the schools and traditions of disability studies have become numerous and its debates highly complex, I'm going to risk an oversimplification. For the purposes of this article, I'll use the terms "social model", "social model

et.al." and so on as an umbrella term, which includes the above traditions. I justify this choice with the observation that the minority model, the feminist approach etc., all share with the social model the goal of explaining how disability is produced by complex social arrangements. As with the particular British social model, they all retain, to some extent, an intention to be a tool for activists. They were all formulated partly to provide a platform for criticizing the kind of oppressive structures that were alleged to stem from the medical model, and they all share a critical attitude to that model.

Disability rights activists, along with allies in the political and academic field, have indeed scored a series of notable successes over the last quarter-century. The best known of these successes may well be the Americans with Disabilities Act (ADA) of 1990, which despite its many flaws and limitations (Krieger 2003) has become a reference points for legislative initiatives in multiple countries. Along with the United Nations Convention on People with Disabilities of 2007, it adopts a framework of anti-discrimination and equality before the law, that is to say a framework in which disability is something that arises when people with different physical and mental capabilities are treated unjustly by the societies of which they are part.

It is an open question, however, how great a role the social model and its close relatives have played in these political battles. Certainly, key figures in academia have frequently been activists themselves, and although legislation such as the ADA was more strongly influenced by the civil rights movement than by theories of economic oppression, the salient common point is that disabled people constitute a class that has been subjected to unjust treatment by society and the state. But it is less than well-known how effectively the models and theories of academia have been integrated in other parts of the disability field.

The birds-eye view of disability history shows medical discourse retreating as social (or socio-political) discourse advances. But there are many unanswered questions about the relationship between the different communities that approach disability as a complex phenomenon that cannot be reduced to biophysical properties of individuals. Two questions in particular will frame the discussion in this article. One concerns the relationship between disability discourse as it is produced in academia and disability discourse as it is produced in the NGO field, which is the main locus for disability activism. Another concerns the dichotomy between the medical model and the social model, and whether that dichotomy is grounded in *any* part of the disability field. The two questions bear on each other in that disability, relatively speaking, is an underdeveloped topic for both activists and researchers. If different agents and communities in the field have shared goals but nevertheless perceive themselves to be in conflict, every effort should be made to explain how the perception of conflict came about, and to replace it with one that is more productive for the field as a whole.

1.1 Research goals

Some aspects of the above questions are not new, and they have been asked in related forms within the context of disability studies before (Shakespeare 2006). This article is an attempt to explore them in the specific context of *discourse in the NGO field*. Clashes between models of disability may be conceptualized on a national or global scale, but they play out in perhaps more significant ways on the level of day-to-day interactions, in everyday discourse. This article discusses one aspect of such interactions, in that it is a critical discourse analysis of the attitudes that professionals from five Norwegian NGOs have to the medical and social models of disability.

The data consists of interviews with the leaders or general secretaries of the respective organizations, whose membership consists of people with different impairments. These NGOs are organized according to medico-diagnostic criteria, and do not necessarily consider themselves proponents of disability rights. Since a large part of the brief for at least four of them is to secure better health services from the state, there is a very real possibility that they *de facto* operate according to the medical model. But they are also members of FFO, a national umbrella organization that unites 70 impairment-based organizations by framing disability as a matter of social conflict. Much of FFO's rhetorical work consists in putting a sociopolitical face on issues that are grounded in illnesses and medically diagnosed impairments (Grue 2009) [i].

Given this context, the question of how the NGO leaders conceive of disability is fairly open-ended. The research goal of this article is to answer that question, at least in part. From this, some subsidiary research questions may be derived. First, how conceptually consistent are the NGO leaders and what is their doxic conception of disability? What justifications do they draw on to legitimize their positions? Are they positive, negative or indifferent to the analyses of disability studies? Second, what political consequences can be inferred from the doxa of the NGO community? Is the current state of affairs desirable, and if not, can it be changed?

2. Material and Methodology

The interviews were conducted according to a one-page guide of salient questions (see the appendix), but were sufficiently flexible that the subjects had the option of clarifying answers, changing the topic (or introducing new topics). The primary topics of the interviews were indicated as being 1) concepts and representations and 2) organizational purpose and identity. The subjects and the

NGOs they represent have been rendered anonymous, but can be briefly characterized as follows:

S1: Male, 30s, leader of mid-sized organization representing people with a congenital impairment with a wide spectrum of health-related impairment effects.

S2: Male, 30s, general secretary of mid-sized organization representing people with a congenital/acquired impairment with a narrow spectrum of effects mainly unrelated to health.

S3: Female, 30s, newly hired general secretary of mid-to-large organization representing people with a congenital though sometimes late-appearance impairment with a wide spectrum of health-related effects.

S4: Male, 50s, chairman of the board for small-to-medium organization representing people with a wide range of health-related effects.

S5: Female, 50s, general secretary of mid-to-large organization representing people with a congenital but often late-appearing impairment with a wide spectrum of health-related effects.

Information about age and gender is included in order to make it easier to distinguish the subjects, information about size of organization and range of impairment effects in order to provide some minimal background. The subjects were at one point asked to identify the relevance of four categories to their particular NGO: Patient organization, political organization, social club/organization or information bureau. Most of the categories were found to be relevant to most of the subjects, as seen in the table below, but it should be noted that S2's omission of both "patient organization" and "social club" may be ascribed to the relatively narrow spectrum of impairment effects in his NGO.

Subject / Category of Organization	Patient	Political	Social club	Information
S1	√	√		√
S2		√		√
S3	√	√		√
S4	√	√		√
S5	√	√		√

Table 1: Category of Organization. Of these categories, some are more amenable to social model interpretation than others, but note that being an organization of and for people who primarily see themselves as medical patients does not preclude non-medical organizational goals.

The subjects' responses have translated into English, but Norwegian originals are provided in endnotes for the sake of accuracy. Since the analysis is largely limited to the semantic features of talk, emphasis has been placed on readability of the subjects' answers rather than detail of transcription.

A note on expectations: It may be necessary to approach the material with one or two hypotheses in hand. On the one hand, the NGO professionals in question are employed by or represent organizations that depend upon medical criteria for their membership guidelines. They are identical in this regard to their 65 sister organizations – the people whom they represent depend on a medical certification in order to claim benefits from the Norwegian state. As such, they should perhaps be expected to chiefly employ medical conceptualizations of disability, if only for the reason that the primary economic function of an organization will usually affect its discourse.

On the other hand, the professionals represent organizations *of* rather than *for* people with impairments. Unlike many pre- or early modern initiatives in the disability field, these NGOs are largely the result of self-

organization among disabled people in order to further their cause, not charitable projects. As such, they might instead be expected to employ sociopolitical frames of reference and to conceive of themselves as a community who share many other things besides a diagnosis. Both of these hypotheses could be greatly expanded. For now, I'll note that there are clear incentives toward adopting both medical and social discourse in the everyday working lives of the interview subjects. Medical discourse will ease the dialogue with health professionals and bureaucrats from state agencies, while social discourse will serve, among other things, to greatly expand the basis for joint political action.

A note on methodology: One point of this article is to capture the stance adopted by the subjects on issues of language and representation of complex phenomena. I've used some of the basic precepts of critical discourse analysis (CDA) and conversation analysis (CA), i.e. attention to lexis and syntax, as well as framing devices, metaphors, emphasis, distancing devices etc. (Fairclough 1995; 2001 [1989]; 2005; 2005; O'Halloran 2003; Weiss and Wodak 2003; Wodak and Meyer 2001).

I also employ the concept of the topos (pl. topoi). A topos is both a) a *place* of common knowledge (cf. *commonplace*) and b) a conclusion rule that may be invoked in discourse interpretation. In CDA, the topos has been developed, with an emphasis on its "warrant" aspect, by Ruth Wodak and others (Wodak and Meyer 2001; Wodak and Pelinka 2002; Wodak and van Dijk 2000). It is described as linking particular arguments to reader background knowledge – *doxa* – of the kind that documents such as the UN Convention mentioned above seek to establish.

Wodak presents topical analysis as a way of discovering the hidden premises of argument:

> Within argumentation theory, 'topoi' or 'loci' can be described as parts of argumentation which belong to the obligatory,

> either explicit or inferable premises. They are the *content-related warrant* or 'conclusion rules' which connect the argument or arguments with the conclusion, the claim. As such, they justify the transition from the argument or arguments to the conclusion. (Wodak and Meyer 2001: 74, emphasis mine)

Thus: 1) A topos is that which justifies a line of argument, but requires less justification itself because it is anchored in common attitudes or doxa. 2) Topoi, being rules of inference, are tied more strongly to *concepts* than to *words*. The same topos can potentially be phrased in numerous ways, and so extraction of topoi will necessitate rewording.

Topical analysis, then, is a method for explicating the justifications that link the general and the specific, and thus also for grounding an abstract concept or model in a more concrete domain. By appealing to the doxa or tacit knowledge of the model reader, topoi both strengthen the argument and suggest the dominant interpretation in the communicative context. In discussing the following passage from "Austria first", a petition by the far-right FPÖ party, Wodak invokes the general/abstract topos of "burden", which she specifies in context as the following conditional: If a person, an institution or a country (i.e. Austria) is burdened by specific problems (i.e. language education for immigrants), one should act in order to diminish these burdens. Thus, particular and concrete policies are justified:

> The adoption of a federal law to change the law governing the organization of schools so that the proportion of pupils in compulsory and vocational school classes whose native language is not German is limited to 30 per cent; where the percentage of children whose native language is not German is higher than 30 per cent, regular classes for foreigners are to be established. (Wodak and Meyer 2001: 85)

3. Analysis

3.1 Stance Towards the Social and Medical Models of Disability

The social and medical models of disability are well known, or, at the very least, the topics of considerable amounts of discourse. There is some balance between the two in the public sphere: A general Google search of the obligatory terms "social model" and "disability" yields 110.000 results, while "medical model" and "disability" yields 102.000 results. The same searches on Google Scholar yields 9.090 and 16.200 results, respectively[ii]. (For comparison, "minority model" and "disability" yields only 1.410 results.) The models are also, in one form or another, mainstays of disability studies and theory, where they have been instrumental in establishing disability as a legitimate topic for academic research. In an organization such as FFO, the umbrella for the NGOs under discussion, they are well known, and the concepts of the social model frame much of the programmatic discourse. Nevertheless, of the five interview subjects, only two were willing and able to provide extensive definitions of them. One provided a guesswork definition, while two avoided the question entirely.

With regard to the social model, the answer run as follows:

> *S1: We in [this organization] aren't familiar with those models. And that says something about us, that we don't engage much with the theoretical, the philosophy-of-society aspect of... er... disability and so on. We're more... in our everyday experience we're not very... well, philosophical-contemplative, we're not that, we're pretty empirical, close to experience [...]*
>
> *S2: ...the social model... which has in a way complemented the medical... where the social is tied to... let's see... and this thing, that society has a responsibility to adapt things for everyone... er... I may be wrong, but still kind of, well... goodwill... the path of good will... er... we need... as long as everyone understands*

how difficult things are for the poor disabled people, things will work themselves out... through good will...

S3: [...] the social model is in a way about my relationship with... or the individual's relationship with his or her surroundings... about how... how one perceives oneself to be disabled or not disabled and how to relate to one's social surroundings and... how to construct a self in the relationship with... well... er... is my disability my self... er... do my characteristics or my knowledge or my skills constitute my self, yes.

S4: Well I don't mean anything by... other than that I've... obviously heard about the different... read about them... in various councils and committees

S5: That doesn't really tell me... well the social model that may relate to as you say that it has to do with social, that is, disabled in social situations...[iii]

Subject 3 provides a fairly extensive discussion of the social model, but does not discuss what may reasonably be termed the key element of the model: That disabilities are primarily caused by social arrangements, not bodily impairment. Subject 4 dismisses the question before he moves on to discuss certain aspects of practical policy work.

Subjects 5 and 2 attempt definitions that hinge on the connotations of the word "social" rather than anything to do with the social model as such. Interpreting the social model as applying only to impairments with a social-interactional component (S5), or as being a program for charitable activity (S2) may be logical extrapolations from "social" to "sociable" or "social responsibility", but neither interpretations fit with the social model as it originated or is employed in disability studies.

The response from Subject 1 is perhaps the most interesting one. He professes ignorance of both the social and medical models, but provides a justification for the ignorance that suggests that it may be feigned. The use of terms such as "philosophical-contemplative" and "philosophy of society" mean that S1 employs academic

discourse in order to emphasize *distance from* academic discourse, stressing the value of everyday experience.

In terms of topoi, S1's skepticism rests on the following justification:

Topos 1: Because the social model is too theory-driven, it holds little relevance for practical work.

S2's objections can be framed as the following warrant:

Topos 2: Because the social model depends on goodwill, it is naïve.

S5 provides only the first half of a conditional, which nevertheless frames the social model as being reductive or insufficient to her NGO's purposes:

Topos 3 (incomplete): Because the social model applies only to social situations…

In all three topoi, we note that the social model is represented as being insufficiently comprehensive with regard to NGO experience.

The medical model is better known than the social model, as we see below:

> *S1: [Coincides with previous answer.]*
>
> *S2: ... medical model is probably the... original... the one that... er... can be linked to for example Foucault and this thing with... categorizing people in different systems and... er... defining every lack in the individual as a medical problem that has to be repaired and fixed. Er... it's dominated... politics in Norway... in most of the years since the war... and... been challenged by the social model.*
>
> *S3: Yes, the medical model is... medicalized Norway or the medicalized world. Where people are* ***incredibly*** *focused on diagnoses and say that if you have... if you have cerebral palsy for instance they you're expected to be able to do this and that, you're expected to have such and such flaws and it's very concentrated on, well, a little like the system of dog breeds in a way if [laughter] yes, but it's a little like that, the medical model and we're* ***deeply*** *wary of it.*
>
> *S4: [Coincides with previous answer.]*

S5: ...and the medical model it has more to do with maybe physical... er... things.[iv]

What is particularly salient in the above answers is the strong identification between the medical model and diagnostic categories *per se*. In disability theory, the medical model is frequently understood to be a far more pervasive and comprehensive way of thinking about disability, one which certainly depends on techniques of medicalization, but which is not restricted to the praxis of the medical profession. Rather, the medical model, as a theoretical construct, is an attempt to explain the construction of the social, political and economic framing of disability in a particular historical period. This includes the institution of rehabilitation, the distribution of welfare benefits, discrimination in the workplace and a host of other phenomena that may be related to but cannot be explained in terms of diagnoses.

The reason this is an interesting finding is that criticism of the medical model originated as a form of mystification analysis, not as a presentation of a viable analysis of disability. While the label “medical model” has survived in the NGO field, the analysis that motivated the label has not. In the interviews, the medical model comes across as a highly reductive vision of disability that overemphasizes "physical things", and describing all individual characteristics as "problems" that can be "fixed", viz. a skeptical description of what happens when doctors and nurses have too much influence on how disability is described. In academic discourse, the medical model is more often thought of as a tool for explaining how medical knowledge has contributed to the naturalization of various categories (e.g. "employable" and "unemployable") that make disability the mark of a distinct form of sociopolitical exclusion. In the NGO field, the label may have come to hinder, rather than promote, the demystification of such categories.

In terms of topoi, S1 establishes a justification that is similar to topos 1:

Topos 4: *Because the medical model is theoretical, it holds little relevance for practical work.*

Both S2 and S3, and to some extent S5, draw on a different topos of reductionism:

Topos 5: Because the medical model addresses only the medical-physiological aspects of disability, it is too reductionist to be of use.

What we are faced with, then, is a set of topoi in which both the medical and the social model are represented as lacking or incomplete – as not covering the full range of NGO experience and activity. This is emphatically not the self-perception of the social model, which was intended as a comprehensive explanation of how biomedical properties of individuals become enmeshed in oppressive political structures. Although the medical model was never meant to be an even remotely viable alternative to the social model, but merely a reductionist and historically outdated form of doxa, it reappears in NGO discourse as one of two unsatisfactory alternatives. The danger is that models that were intended as tools for critical thinking are rejected or abandoned, leading to an NGO field which is less progressive in its encounters with state agencies.

3.2 Discourse and Political Expediency

The skepticism towards both models is elaborated in the answers of subject 1, who repeatedly stresses the importance of everyday experience to the work of the NGO in question:

> *S1: [this organization], where one isn't really concerned with that, with those words. One was more concerned with having a lot of problems and that people are very different and that it's a matter of doing of trying to do as well as possible with the problems one has and be inclusive in practice, in a way. [...]*

> *There just isn't energy to think so much so big thoughts about it.*[v]

Here, topoi 1 and 4 (about the models' overly theoretical bent) are grounded in propositions about NGO work: The work is of a practical nature, it does not include interpretational duties, it does not leave room for thinking "big thoughts". All three of these mesh with topoi 1 and 4 and provide justification for rejecting both the medical and social model. The anti-theoretical attitude is, however, particularly incompatible with social model analysis:

> *S1: It's popular in some circles to say that it's not, it's kind of the environment that creates the disability and it's not, it's when encountering the environment, and it's the fault of the environment. […] But to in a way become so concerned with sharpening that interpretation that you eventually begin to ignore the fact that somebody has a damned big problem because the body doesn't work and maybe even the thinking process sometimes fails you so you get lost or you don't remember what to do... it almost gets a little silly sometimes.*[vi]

Here, we see further elaboration of topos 1 (*Because the social model is too theory-driven, it holds little relevance for practical work.*) Interestingly, the emphatic markers and thumbnail sketch of the social model ("it's the fault of the environment"), combined with a certain respect for its political expediency, partly reproduces a debate that has been salient in (particularly British) disability studies over the last fifteen years, as the Marxian analysis of political and economic causes of disability has been criticized as underplaying the significance of impairment effects such as pain and fatigue (Thomas 1999; Wendell 1996). Note that although S1 stated very early in the interview that philosophical and theoretical debates were alien to the everyday work of the NGO, we have nevertheless (at approximately 2/3 of the way through the interview) visited the key sites of one such debate. S1's distancing from such debates therefore needs to be explained some other way.

The above pattern, although most explicitly voiced by S1, is recognizable in the comments of the other interview subjects. Usually, the matter of political expediency is made relevant in order to justify the lack of an overarching theory or model of disability:

> *S2: We debate a lot, and some... we have [one fraction] and here somebody will be quite radical in their views [...] and distance themselves from any... categorization of disability. Whereas others will be a little more balanced, nuanced, and se that there are elements that are both, go both ways. And [this organization's] official policy is that we are... aware of both... ways of seeing [the diagnostic group]. [...] [One position states that:] We don't have a problem, it's society's problem. Er... whereas others will... accept being labeled as disabled... because one sees that there are barriers in society that have to be removed before one can participate fully.*
>
> *S4: Of course when you meet medical professionals you meet one language and when you meet politicians with... with their language, of course you do, there's a difference. And... I see that often they talk, however intellectual they are and however upscale a language they use, to call it that... there's still, we often discover that they talk past each other and spend a lot of time... understanding what they're really discussing. [...] The most important task for our organization is to achieve real influence. That is, where the influence is real.* [vii]

In both S2 and S4's comments, we see reinforcement of topoi 1 and 4 (*Because the social / medical model is theoretical, it holds little relevance for practical work.*), again grounded in the necessities of NGO work ("there are elements that are both", "there are barriers", "to achieve real influence"). We can add the following topoi:

Topos 6: Because NGOs include multiple factions, multiple theoretical positions have to be entertained.

Topos 7: Because NGOs address multiple audiences, multiple theoretical positions have to be entertained.

There is an admixture of social model and medical model approaches to specific impairments in the subjects' answers. On one level, this is hardly surprising. The NGOs

in question are by definition engaged in practical work; they are neither think tanks nor academic institutions. But, significantly, their everyday conceptualizations, as expressed in the interviews, can be viewed as a rejection of models and theory in general. In other words, the NGO discourse, while it is committed to attacking the barriers that were largely identified thanks to the social model, the minority model *et.al.*, does not endorse the models as such. This begs the question of what will sustain the identification of future barriers and future factors that may contribute to the construal of disability as personal tragedy.

3.3 Theory and Practice

Social model theory, and indeed disability studies in general, is concerned with tasks such as destabilizing categories of normality and abnormality, providing the intellectual foundations of disability identity or identities, and situating disability within a historico-cultural matrix, to name a few. One ambition is to provide a comprehensive explanation for what disability is, and, for most practitioners of disability studies, to frame these explanations in such a way as to affect policies that have impact on the lives of disabled people. The point is not theory for its own sake, but theory in the service of critical analysis.

The last point may not be obvious to professionals and volunteers in the NGO community – not least because it is frequently forgotten by academics. A recurring point in the interviews is an aversion on the part of the subjects towards "intellectual" or terminological issues, viz. towards much of the academic sections of the disability field. The most important common denominator for the topoi (in particular T1, T4, T5, T6 and T7) listed above is their indication of a doxa in which academic theories simply do not hold relevance for everyday work, because they are perceived as being either too rigid or too narrow.

I'm going to present two propositions on the nature of this breach between the NGO and academic fields: First, that the distance is artificially great, and second, that it is in the interest of and a responsibility for academics, NGO professionals and activists to try to decrease it.

That the differences between NGO language and academic language is greater than that between the prevalent ideological positions in the respective fields – or alternately, that the discourses are in fact produced from similar ideological positions, should to some extent be demonstrated in the above analysis. Firstly, many of the key debates and topics from academic disability studies can be identified in the NGO field. Secondly, the most important tenet of the social model *et.al.* – that society has to be changed in order to end oppression of and discrimination against people with impairments – recurs at multiple points in the NGO discourse.

This tenet is not necessarily compromised by the usage of some discourse elements that are conventionally associated with the medical model, such as a strong link between illness, diagnosis, impairment and potential treatments or interventions. The matter can, rather, be framed as a matter of contextualization: When social model tenets are brought to bear on specific political or bureaucratic problems – transportation, IT accommodations, welfare benefits – some discourse involvement with diagnoses is inevitable. The appearance of medical model elements in NGO discourse does not compromise the social model framework in which they appear. Nowhere in the material for this article do the interview subjects frame disability as primarily or even mainly a medical problem.

An explanation for the expressed skepticism towards the social model as such can likely be found in the connotations social model terminology and *academic* rather than *policy* discourse. The social model is underdeveloped with regard to policy implications (Samaha 2007), and may be over-associated with

academic over-abstraction, even though it is in academe that it has been articulated at its most nuanced. If so, the problem is one of communication between social fields rather than one of conflicting theoretical models.

Note that the translation problems between social fields are not ubiquitous. With respect to the built environment, the social model has found a highly successful policy tool in *universal design*. Notwithstanding the fact that "universal" design in practice means accommodating a large, but not unlimited range of human capability (and consulting with various, frequently diagnostically organized groups), it is intuitive to most people that building a ramp is a better solution than trying to get every wheelchair user in the city to walk up steps.

In other areas, the policy implications of the social model are not as clear. To name but one example: In the context of higher education, medical certificates can provide access to extra time during exams, the use of a computer when such use is not available to other students, etc. Is this a way of segregating students with impairments, of segregating them from the general population? And if it is, is there any way around the problem? Could exams be set up without strict time limits, and with a full range of technical equipment available for all? Would this be fair? The balance between accommodations that relate to the attributes of individuals (and are thus susceptible to naturalizing of difference) and institutional reform is often difficult to strike.

4. Conclusion: Conflicting with or Co-Opting the Medical Model

Relative to the percentage of the population that has an impairment of some sort, few people seem to think of themselves as having an identity as a disabled person (Shakespeare 2006). Disability is not currently, even with the promotion of "crip culture" and more frequent disability pride parades, a very desirable identity. It will

never, of course, be genuinely desirable to acquire an impairment. The question, rather, is whether people will prefer openly adopting a disabled identity to either trying to pass as non-disabled or opting for an ostensibly temporary sick role. A corollary to this is the question of what the disabled identity is *for*.

To the NGO professionals interviewed for the article, it seems obvious that most of their organizations' members deal with medical difficulties on a regular basis, and that a primary function of organizational work is to ameliorate those difficulties. (It should perhaps be noted that dealing with medical difficulties is a salient feature of being human, to a much larger extent than it is a feature of being disabled.) Now, the experience of disability shares many features with the experience of chronic illness, and, even more importantly, the lives of people with both forms of experience can be improved through many of the same social changes. There is certainly a need for an extensive discussion of medical knowledge within the framework of the social model. At the same time, certain causes of negative features that are specific to the disabled experience become invisible or obscure when individual illness is given too prominent a place. Producing medical knowledge does not entail adopting a medical model, but neither does a model of disability that can be used to progressive ends automatically absorb medical knowledge. That takes work.

While there are few theoretical barriers to such a project, the reception of the medical and the social model in the NGO field, as discussed in this article, suggests the following: When the social/medical dichotomy that originated in the academic field is recontextualized in the NGO field, something important changes. Instead of being perceived as a theoretical construction within the social model, the medical model becomes an alternative and equally legitimate framework for the analysis of disability. The social model, which was intended as a basis for a comprehensive analysis of disability (including its medical

aspects), becomes reduced to one of two undesirable choices: A false dichotomy comes into being.

It would appear, then, that what has often been conceptualized as a binary conflict between social and medical models of disability is just as much, if not more, a conflict between the discourse of different *social fields*. The academic origins of social model terminology and framing continues to cause negative reactions in the NGO field, even as the ideological content and drive is deployed in specific policy arguments. This is detrimental to dialogue in the disability field, and hampers the critical potential of the NGOs. In order to erase the false dichotomy, in order to provide a more solid foundation for the political and policy work of disability NGOs, it seems necessary both to show the use of that discourse in relation to the goals of the social model and its fellow analytical tools, and to extend and reinterpret the model itself within as many different discourses as possible.

Appendix: Interview Guide

Introductory Information

Which organization do you work for, and in what capacity?
How long have you had this job?

Concepts

What is your first association to the word "disability"?
What do you understand "disability" to mean?
What do you understand "impairment" to mean?
What does it mean to be disabled, or to have an impairment?
Are you familiar with the social model, the gap model or the medical model of disability? What do you understand them to be?

Organizational profile

How would you describe the key purposes and tasks of your organization?

How would you characterize the members of your organization?

What is the most important thing the members have in common?

Can your organization accurately be described as one or more of the following: a) patients' organization, b) political interest group, c) society for spreading information d) social club?
How would you expect the members of your organization to respond to the previous question?

Notes

[i] A note on my own position as an analyst: The article is part of a PhD project which includes the analysis of written documents produced by FFO and of a 2009 Norwegian anti-discrimination law. The project, funded by the Research Council of Norway, was initially conceived as an exploration of whether the social and medical models are in conflict in the FFO system. This has naturally influenced the direction of my research. I've since attempted to expand the scope of the project somewhat, but the focus remains on discourse that is germane to the praxis of the NGO community.

[ii] Searches made on February 10, 2009. The goal here is not to provide a precise view of the relative importance of the medical and social model, but simply to suggest that they are established and prominent terms.

[iii] Original transcript, in Norwegian:

S1: Vi i [denne foreningen] kjenner lite til de modellene. Og det sier noe om oss, at det er ikke der vi fordyper oss så veldig på det teoretiske, sosialfilosofiske rundt... eh... funksjonshemning og sånt. Vi er mere i... vår nære erfaring er vi ikke så veldig... ja, filosofisk-reflekterende, vi er ikke det, vi er ganske erfaringsnære, erfaringsbasert [...]

S2: ...den sosiale modellen... som på en måte har utfylt den medisinske... der det sosiale knyttes til... skal vi se... også dette med at samfunnet har et ansvar for å legge til rette for alle... ee... mulig jeg tar feil, men fremdeles kanskje litt sånn ehm... den gode vilje, den gode viljes vei... ee... vi trenger... bare alle forstår hvor vanskelig de stakkars funksjonshemmede har det så vil ting løse seg etter hvert... gjennom den gode vilje...

S3: [...] den sosiale modellen handler på en måte om min relasjon til... eller individets relasjon til sine omgivelser... om hvordan... hvordan man oppfatter seg som funksjonshemmet eller ikke funksjonshemmet og hvordan kan man forholde seg til sine sosiale omgivelser og... hvordan man bygger jeg'et i forhold til... altså... ee... er min funksjonshemning mitt jeg... eller er mine karaktertrekk eller mine kunnskaper eller mine ferdigheter mitt jeg, ja.

S4: Altså jeg legger ikke noe i... annet enn at jeg... har selvfølgelig hørt om de forskjellige... lest om de... i forskjellige råd og utvalg.

S5: Det sier meg liksom ikke... altså den sosiale modellen det kan jo gå på som du sier at det har med sosiale altså funksjonshemmet i sosialle sammenhenger...

[iv] Original transcript:

S1: [Se forrige svar.]

S2: ...medisinsk modell er vel den... opprinnelige, den som... ee... kan knyttes tilbake til for eksempel Foucault og dette her med å... kategorisere mennesker inn i forskjellige systemer og det å... ee... definere enhver mangel hos individet som et medisinsk problem som må repareres og rettes opp. Ehm... den har vel dominert... norsk politikk... i de fleste år etter krigen... og... blitt utfordret av den sosiale modellen.

S3: Ja, den medisinske modellen er jo... det medikaliserte Norge eller den medikaliserte verden. Hvor man er... ***utrolig*** *diagnosefokusert og sier at har man... har man CP da for eksempel så er man forventet å kunne klare de og de tingene, man er forventet å ha de og de feilene og det er veldig oppbygget rundt, altså litt sånn rasesystem for hunder på en måte hvis [latter] ja, men det er litt sånn er den medisinske modellen og den der vi jo* ***dypt*** *skeptisk til.*

S4: [Se forrige svar.]

S5: ...og den medisinske modellen den går jo da mer på kanskje fysiske... ee... ting.

[v] Original transcript:

S1: [denne foreningen], hvor man egentlig ikke er så opptatt av det, av de ordene. Man var mer opptatt av at man har masse problemer og at folk er veldig forskjellige og så er det om å gjøre å prøve å ha det best mulig med de problemene man har og være inkluderende i praksis på en måte. [...] Det er liksom ikke helt overskudd til å tenke så mye sånne store tanker rundt det.

[vi] Original transcript:

S1: Det er populært i enkelte miljøer å si at det er ikke, det er liksom omgivelsene som skaper funksjonshemningen og det er ikke, det er i møtet med omgivelsene, og det er på en måte omgivelsene sin skyld. [...] Men det å på en måte bli så opptatt av å rendyrke den forståelsen at man til slutt begynner å overse at faktisk har noen et jævla stort problem fordi at kroppen ikke virker og kanskje til og med tankegangen av og til også svikter deg så du ikke finner veien eller du husker ikke hva du skal gjøre... så blir det nesten litt tullete noen ganger.

[vii] Original transcript:

S2: Vi diskuterer mye, noen altså... vi har [én fraksjon] så her vil noen være... ganske radikale i sin oppfatning [...] og ta avstand fra enhver... kategorisering som funksjonshemmet. Mens andre vil være litt mer balanserte, nyanserte og se at det er elementene er begge, begge deler. Og [denne organisasjonens] sin policy offisielt er at vi er... oppmerksomme på begge... mulige måter å se [diagnosegruppen] på. [...] [den ene posisjonen tilsier:] så vi har ikke et problem, det er samfunnet sitt problem. Ee... mens andre vil... akseptere å få merkelapp som funksjonshemmet... fordi man ser at det er barrierer ute i samfunnet som må fjernes før man kan delta fullt og helt.

S4: Det er klart at når du møter medisinerne så møter du ett språk og når du møter politikerne med... med sitt språk, så klart at du gjør det, at det er forskjell på det. Og... jeg ser jo at ofte så snakker, selv om de er aldri så intellektuelle og bruker fint språk så, om vi skal kalle det... så er det likevel, vi oppdager det at ofte så snakker de forbi hverandre og bruker mye tid... på å forstå hva de egentlig snakker om. [...] Den viktigste oppgaven for min forening det er jo å nå frem til reell påvirkning. Altså hvor påvirkningen er reell.

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Discourse analysis and disability:

Some topics and issues

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Disability is an underexplored topic in discourse analysis. A stronger emphasis on disability issues would be in keeping with the academic principles and political priorities of critical discourse analysis. Simultaneously, a discourse analysis perspective is needed in disability studies. Although that field has produced a considerable amount of discourse-oriented research, it is structured around theoretical models that appear adversarial and incompatible. In practice, many of the incompatibilities dissolve into divisions between different areas of discourse production. A greater awareness of discourse analysis will aid disability studies both in terms of theoretical development and in furthering its goals of social change.

Keywords: disability, discourse analysis, models, topoi, dichotomies, fields

0 Introduction

The identity markers of class, gender, race, and ethnicity are being supplemented by that of *disability*. The United Nations Convention on People with Disabilities was adopted in 2007; so far, it has been signed by 144 countries and ratified by 48. Disability, which was for a very long time impossible to discern in the mosaic of the cripples, the freaks, the blind, deaf, and dumb, has been articulated as a distinct pattern of oppression, discrimination and stigma.

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Disability studies, which has become an established academic discipline, aims to explore new territory. Like other disciplines that have their origins in activism, it has maintained a concern with issues of social justice. In some countries, the academic study of disability provides government agencies and others the information they require in order to supply adequate services for people with impairments, and to compel such agencies to consider the needs and rights of people with impairments in areas where they did not previously do so. The establishment of disability studies has also been a way of opening new fields of inquiry, of producing new knowledge about human experience and altering, refining or subverting old truths. On this basis, discourse analysis and disability studies are engaged in much the same pursuit.

Why the need for discourse analyses of disability, then, if this is already being practiced on disability-related topics under different headings and in different journals? First, because the ties between disability studies, activist circles, and policy development, are weakened by academic infighting and an adherence to the misguided notion of mutually exclusive theoretical models of disability. Second, because disability studies is showing signs of becoming introverted and circumspect, with too little energy on building connections with sympathetic disciplines and fields.

This has three purposes. One is to present some of the research on disability that should be of interest to discourse analysts. Another is to clarify the problem of mutually exclusive theoretical models of disability in terms of discourse. The last is to discuss the undeveloped or at least underdeveloped potential for applying the theories and methods of discourse analysis to the topic of disability, and some reasons for doing so.

1 The lack of discourse research on disability

While disability is an emerging and increasingly significant area of academic inquiry, it is sparsely covered by discourse studies in comparison with similar topics – and by "similar", I mean other categories that define minority or stigmatized identities. The following three items do not represent an exhaustive overview of disability as a research topic for discourse analysis – to my knowledge there is no such overview – but they provide a rough index of the current state of affairs:

a) Out of the 79 research articles selected for the SAGE anthology Discourse Studies (van Dijk 2007), I counted 9 articles that extensively addressed or thematized gender and gender roles, 6 articles on race and racism, 7 on party politics and political ideology, and a single article on (in this case, learning) disability.

b) A search on Google Scholar (on January 26, 2010) returned the following results for "critical discourse analysis" plus the following keywords:

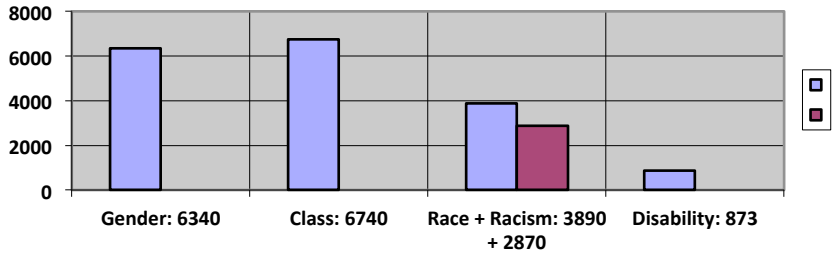

Table 1: Search results from Google Scholar.

c) Finally, from the following three journals that include CDA as part of their publication brief, I got (on the same date) the following keyword results:

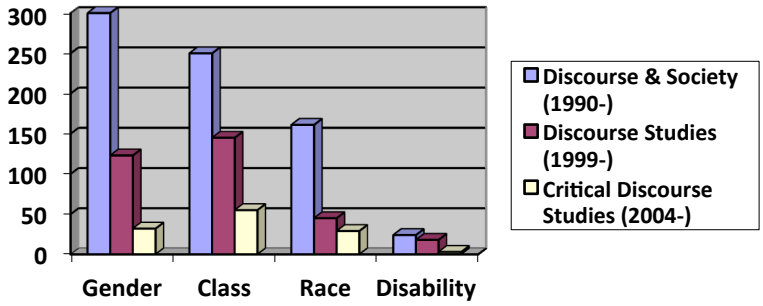

Table 2: Incidence of keywords in journals.

It seems that disability has not yet become a major topic of interest for discourse research. But given the social and political ambitions of discourse analysis, disability should be considered a legitimate and compelling research topic. Disabled people across the globe are politically, economically and culturally disenfranchised. In many Western countries, progress has stalled or been reversed with regard to social justice, economic redistribution, and key quality-of-life issues. The current flowering of disability studies as an academic discipline is not accompanied by substantial material gains. This situation – as I'll discuss in the following – is shaped by forces that can best be addressed in terms of discourse.

Moreover, disability studies is a still-emerging academic field, and its key theoretical and methodological debates will benefit from interaction with discourse analysis. While disability studies has been engaged in a conversation with itself about its methods, goals and strategies for some time, I believe that the discourse perspective can help clarify some of the issues at hand.

2 Research on disability with a discourse focus

There is little doubt that disability, taken as a complex and multi-dimensional phenomenon, exhibits many of the features that are displayed by many of the canonical topics of discourse research, e.g. racism and gender. While disability has a material component that is inextricably linked to individual bodies, e.g. lack of vision, hearing or the ability to walk, the consequences that this biophysical has for the individual in question is to a huge extent a matter of sociopolitical dynamics.

This is an insight that was slow in the making. The social meaning of mental or physical impairment has varied enormously over time(see Stiker 1999 [1982] for an extensive discussion), but a common theme in the history of impairments is that of their being targets of intervention (whether well-intentioned or malevolent) rather than sources of sociopolitical change. The person with the impairment was the one to be patronized, blessed, left to die of exposure, institutionalized, cured or rehabilitated. Society was fine the way it was.

While exceptions can certainly be found, such as the League of the Physically Handicapped who marched on Washington for the right to work in 1935 (Longmore 2003: 57), disability first became a major warrant for social transformation in the 1970s. A full historical survey is beyond the scope of this article, but it feels necessary to mention the sociological writings of I.K. Zola in the United States (Zola 1972), the manifesto of the Union of Physically Impaired Against Segregation in the United Kingdom (UPIAS 1976), and – to an extent – welfare reform in the Scandinavian countries.

The implications of this critical turn in disability discourse were considerable. Earlier efforts by figures such as Erving Goffmann (1963) had advanced the possibility that disability constituted a discrete and problematic social role, but from the end of the 1970s onwards, the ways in

which society *creates* disability by allowing barriers to be built, whether social, economic or architectural ones, have become impossible to overlook.

Disability studies, therefore, aims to make explicit the discourses that reproduce disability as an oppressive category. One such discourse is that of the normal/abnormal, in which deviations from the statistical mean of human ability or appearance are construed as monstrous or deeply pathological. Another is that of the employable/unemployable, in which the same statistical mean is used as the basis for a strict socioeconomic role, e.g. the 8-hour-a-day wage worker.

In both cases, qualities that are best understood on a finely graded or continuous scale (health, physical fitness, appearance, etc.) become divided according to a dichotomy of able-bodiedness and disability, with considerable consequences. Being classified as disabled will, at least in most social democracies, entitle one to a number of rights and benefits. But such a system also keeps wheelchair users out of workplaces with staircases, and blind people from working in offices that do not invest in either text-to-speech or Braille translation. Analyzing disability in its social context, therefore, has become an multitudinous enterprise that is critical in basic attitude and extensively concerned with the mechanics of discourse

The roots of discourse-focused disability studies can be found in mid-century sociology, as with the work of Goffmann and Zola, and somewhat later in history, as with Stiker. From the mid-1990s onwards, however there is a significant expansion of disability studies as an interdisciplinary endeavor. Both in the US and in the UK, scholars in the humanities and the social sciences started to undertake research with a focus on the discourses of disability, whether explicitly, as in the anthology *Disability*

Discourse (Corker and French 1999), or implicitly, in the course of anthropological, sociological or literary investigations.

Four main strands of disability discourse studies can be discerned from this period onwards. First, particularly in the United Kingdom, disability research that aimed at **criticizing the social model**, or recalibrating it, often took a discourse approach, by engaging with the problematic nature of the disability/impairment dichotomy of classical social model scholarship. This first strand began as a field-internal debate. Much of the idea that non-medical disability studies could in fact become a viable distinct academic endeavor, at least in the United Kingdom, depended on the notion that disability could be defined as a socially constructed phenomenon – and this notion was largely limited to scholars that understood themselves to be working in disability studies.

As criticism of the early social model emerged, however, there was a noticeable interdisciplinary expansion. Some of the revisionist approaches to the social model have been grounded in philosophy (Kristiansen, Vehmas, and Shakespeare 2009), some in law (Samaha 2007), and many of them share a pervasive interest in language and language use. By showing that the term "impairment", just as much as "disability", derives its meaning from discourses of public health, gender, sexuality, and class (Shakespeare, Davies, and Gillespie-Sells 1996; Thomas 1999; Wendell 1996), researchers pointed out the socially constructed aspect of the fundamental dichotomy of the field. If what constitutes an impairment depends on language and power structures, then the study of those structures must be of key importance.

Second, in the Foucauldian vein, there have been studies of **the history of institutions and medical practice** (Gleeson 1999; 2001b; Tremain 2005). Particularly from

the 19th century onwards, in Western societies, the institutionalization of disabled people can be read out of documents, including case histories, building plans, codes of conduct, etcetera. The expansion of state power and state interventionism has been particularly noticeable for disabled people, who in one sense constitute the ideal type of Foucault's "subject" both a subject *of* (medical) study and a subject *to* medical and para-medical power.

Many of these studies draw on clinical interviews and medical archives; some have been focused on biographical texts (Lombardo 2008) – this last category is frequently analyzed with a view to redescribing the oppressive categories of particular sociohistorical contexts. Others again have focussed on laws and legal texts; one scholar documents the extensive use of legal force to regulate the conduct of disabled people in public spaces, as well as the close relationship between disability and various undesirable social categories, i.e. poverty and vagrancy (Schweik 2009).

A frequently recurring goal in these studies is the construction of a genealogy of disability as a socially meaningful category. As the historical focus is brought closer to the present, attention tends to shift to the discourses of the *welfare state* (Stone 1984), whether in its traditional European or minimal North American incarnation, and for the clinical-medical discourses on which the mechanics of the welfare state depend. As state bureaucracies expand, so does the wealth of texts written about disabled people, and the discourse structures that define their social identity.

The major findings in this part of disability studies center on the Janus-faced nature of most welfare bureaucracies, i.e. on the way in which disability is a marker of both positive and negative social facts. Documentation of (legitimate, medically certified) disability provides access

to certain rights and privileges, to a secondary economy based on *needs* rather than *productivity*; nevertheless, access to this secondary economy is jealously guarded by most bureaucracies, and accompanied by a considerable loss of personal autonomy, as well as social stigma.

Third, there have been numerous **intercultural investigations** of disability, most often conducted by anthropologists (Kohrman 2005; Livingston 2005; Petryna 2002), that demonstrate the importance of national or regional cultural discourses for the meaning of disability. In this tradition, oral texts, whether interviews with disabled people or with the professions that influence their lives, are the primary data.

This third strand is closely intertwined with the second; from the United Nations' Year of Disabled Persons in 1981 onwards, there is a considerable expansion of western (rights-based, welfare-state connected) discourses of disability into the global sphere. Matthew Kohrman's studies of China, in particular, point out the (largely positive) consequences of a rapid introduction of human rights discourse in a traditional national discourse of disability.

Fourth, there is a considerable research tradition that centers on the various cultural discourses of disability that manifest themselves in art, literature, cinema and various other narrative texts or performances. Here, American scholarship is clearly in the lead. There are studies of the discourses of aesthetics and theory (Siebers 2008; 2010), of aesthetics and interaction (Garland-Thomson 1996; Garland-Thomson 2009), and of narratives in the Western literary canon (Snyder and Mitchell 2000; 2006). Additionally, certain canonical figures of disability history have given rise to studies, e.g. of Franklin Delano Roosevelt's and Helen Keller's strategies of discourse

management (Gallagher 1985; Houck and Kiewe 2003; Kleege 2006).

Much of this fourth strand is activist research, aimed at subverting or overturning hegemonic aesthetic standards or conventional readings of established texts. The history of art and literature is filled with characters and subjects that can reasonably described as "disabled", from Oedipus and Hephaestos, through Richard III, Ahab, and Tiny Tim, to Forrest Gump and Raymond of *Rain Man*. Disability studies has largely approached these characters with a view to understanding both how disability functions as a representational tool, and how ideology is expressed by means of disability.

The overall picture of disability studies at this juncture, confirmed by the second edition of the interdisciplinary *Disability Studies Reader* (Davis 2006), is of a discipline that is just beginning to produce a new and critical generation of researchers. Many of the first-wave activist-scholars are retiring or have retired, and are in many cases being replaced by academics that are, to a greater extent, either professional disability studies scholars with fewer connections to activism, or scholars that have approached the subject of disability from other disciplines entirely. The effects of this transformation are profound; they include the risk of weakening the social impact of disability studies, but also the potential for putting disability on the agenda of other sociopolitically active research fields.

In one sense, of course, there is no lack of research on disability, and it might perfectly well be argued that disabled people are archetypal research objects – for medical science, but also for the social sciences and even the humanities. The study of deviation from biophysical, social or aesthetic norms has deep roots. Disability studies distinguishes itself as a discipline, therefore, primarily by a

shift in framing, points of reference, and discourse. The establishment of disability studies has partly been a matter of theorizing disability in a way that is radically different from the previous efforts of e.g. medical sociology, of establishing a different set of causal relations that link disability not only to bodily factors, but to sociopolitical organization. To a great extent, this endeavor has been successful. A significant danger to the further development of the field, however, has been posed by the spread of mutually exclusive theoretical models of disability. This is the topic of the following section.

3 Theoretical models of disability

As indicated above, there is no single dominant school of disability research, but an array of different approaches, grounded in, to name a few examples, literary analysis, sociology, anthropology and Marxist political economy. In terms of theory, too, several distinct *models of disability* can be discerned. These models have usually been perceived as incompatible, and their incompatibility constitutes a major road block to theoretical development in disability studies.

3.1 The social model

The analysis of disability that is codified in the *social model* remains strongly influenced by the model's origin in 1970s Britain. It was pioneered by a group called the Union of the Physically Impaired Against Segregation, and first articulated in the form of a manifesto entitled *The Fundamental Principles of Disability* (UPIAS 1976). The social model was subsequently developed along the analytical lines of Marxist sociology. Disability was explained, relativelt strictly, as a form of economic and political oppression enacted on people whose bodies did not conform to the needs of industrial capitalism (Barnes, Mercer, and Shakespeare 1999; Oliver 1990; Oliver 1996b; Oliver 1996c). This analysis has been expanded through

historical studies that trace the parallel emergence of a strong boundary between work and home life and the increased institutionalization of physically and mentally impaired people (Gleeson 1999; Gleeson 2001b), and work in human geography that documents the significance of the built environment in constructing spaces that effectively divide the population into disabled and non-disabled groups (Gleeson 2001a; Imrie 2001; Imrie and Kumar 1998; Imrie 1996).

The social model has proved valuable in focusing attention on the systemic factors that shape the meaning of disability, particularly those that have to do with political economy. It has been considerably less successful in theorizing impairment as a bodily and embodied phenomenon. This has been acknowledged as a challenge by both the key proponents of the model (Oliver 1996a) and those who have subjected it to criticism with the aim of extensive reform and revision (Shakespeare 2006). One of the founding – and recurring – problems with the social model is that it has been slow and reluctant to embrace the aspects of disability that are intrinsically embodied, because the discussion of these aspects have been viewed as politically counterproductive or devoid of interest in a Marxist theoretical framework. A frequently raised criticism of the model is that it has been constructed around an ideal disabled person, a male wheelchair user belonging to a dominant ethnic group, who suffers no significant health problems because of his impairment.

3.2 The minority model

The above criticism leads into the *minority model*, which is more strongly identified with research done in the United States. This is no accident; on both sides of the Atlantic, disability activism and research drew on the intellectual currents of the times, and the role played by class consciousness and the labor movement in the United

Kingdom is to some extent mirrored by the American civil rights movement and growing awareness of discrimination due to race and ethnicity.

If the publication of the UPIAS manifesto in 1976 is sometimes mythologized as the Year Zero of the disability movement in Britain, a similar American moment can perhaps be discerned in the occupation of Health, Education and Welfare offices in nine cities in 1977 (Longmore 2003: 105-107). Significantly, this action was directed toward the expansion of civil rights to cover the needs of disabled people, and the demonstrators who occupied the San Francisco offices were aided by, among others, members of the Black Panther Party.

In the decades that followed, the (cultural) minority model of disability was applied through activism and lobbying that ultimately led to the landmark Americans with Disabilities Act of 1990, but it was also applied in academic studies that positioned disability as a form of complexly embodied identity that is not a priori positively or negatively charged (see Siebers 2008 for the most recent summary of this position). The influence of the minority model can also be felt in studies that position themselves more directly as cultural history or literary criticism and explore disability as a motif or narrative device, albeit one with social and political ramifications (Garland-Thomson 2009; Snyder and Mitchell 2000).

The minority model, in which disability is explained as primarily a form of cultural otherness, probably fits the case of Deaf people best. The capital D is intended to mark deafness as a cultural and linguistic identity, one which in the United States is strongly tied to Gallaudet University, established in 1864 as the world's first institution specifically designed to accommodate the deaf and hard of hearing. Some Deaf people and organizations wholly reject the disability label, seeking instead parallels with gay and

lesbian communities (Breivik 2007). A parallel development can be found among people and relatives of people with autism, who are currently advancing the concept of *neurodiversity* as a marker of cultural identity (Antonetta 2005). The minority model has been less successful, and to some extent less interested, in explaining the continuing economic and political marginalization of disabled people, a phenomenon which (in the United States) has persisted and possibly increased during the time since minority rights-based legislation was first introduced (Colker 2005; Davis 2002; Krieger 2003).

It also seems to be the case that minority rights ideology, and with it the minority model, is an option for what is effectively a small minority of people who might count as disabled. Although Disability Pride marches have become a regular feature of some communities, notably in the San Francisco Bay Area, the movement is very far from being comparable to, reaching for the most obvious parallel, the Gay Pride movement. Although a discussion of the reasons for this lie beyond the scope of this article, it should probably be noted that a large proportion the of people who count as disabled in the context of most forms of legislation have either hidden impairments or chronic illnesses. The minority strategy seems to appeal more strongly to people who are either not in a position to "pass" as non-disabled in any case, or who consider their impairment to be a form of biological difference to be valued, not "fixed" or "healed". For many disabled people, however, their impairment is something very undesirable indeed, not something to be put at the forefront of their social identity.

3.3 The gap model

The *gap model* does not take a position on this issue, but simply acknowledges that a proportion of the population

will at any given time have either impairments or illnesses that place certain restraints on their functional capacities. Disability is explained as the gap between those capacities and the opportunities offered by society and its institutions; disability is therefore something that can and should be addressed by the full spectrum of policy tools, ranging from medical intervention, when appropriate, to anti-discrimination measures directed at employers, academic institutions, commercial entities, etc.

The gap model, which is mostly identified with policy and research in the Scandinavian countries (Tøssebro 2004), can be linked to the institutional arrangements that, for example, allow for benefits to be paid to people who are deemed medically incapable of working in order to secure a given standard of living – the backbone of most modern welfare states (Stone 1984). It is nevertheless under-theorized, and is not of necessity tied to any particular political system. What actually constitutes closure of the gap is frequently left open. I mention the gap model here not primarily for its theoretical contributions, but because it is the model that seems the most aware of the importance of state bureaucracies in the social construction of disability, e.g. in recent Norwegian disability rights legislation (Barne- og likestillingsdepartementet 2008). It is also an entry point into the fourth and most problematic model.

3.4 The medical model

The *medical model* has been described in sociological works, primarily from the UK (Barnes, Mercer, and Shakespeare 1999; Oliver 1992; Oliver 1996c). Although the term itself is extensively used, it is difficult to find any discussions that are not critical or wholly dismissive of it. In fact, it may be an open question whether the medical model is even a model – though it is consistently presented as such – or simply a series of local examples of

medicalization, i.e. the reduction of various aspects of disability to medically recognized phenomena. The medical model is, however, the nemesis of advocates that employ all the three models discussed above. It is described as an ideological framework that reduces every aspect of disability to bodily impairment, prescribes only medical treatment and normalization as appropriate interventions, and denies agency to disabled people while reserving power for medical professionals.

This description no doubt accurately reflects the inhumane treatment experienced by disabled people in hospitals, rehabilitation centers and other institutions over the course of the last few centuries. I question, however, the wisdom of continuing to refer to the procedures and practices of medicalization as a *model*, at least outside of historical studies, because the end result of this strategy may be to keep alive the illusion that it provides a theoretically viable perspective on disability.

4 The limitations of models

The above divisions constitue a common taxonomy of the disability field. The social model, minority model and gap model are something like theoretical poles by which various researchers and activists navigate, as well as principles that guide legislation and disability policy. The social model, in particular, has become a political-ideological yardsticks according by which actions and statements can be measured, and affects the production of academic discourse by means of key peer-reviewed journals like *Disability & Society*.

Unfortunately, none of the models have succeeded in providing a full account of disability, and none of them appear to be in a position to do so without substantial theoretical revisions. Among the main objections to each of the first three is that a) the social model does not

properly acknowledge biophysical causation, b) the minority model does not account for economic and political causation, and c) the gap model assumes to an utopian extent that the gap between ability and expectation can always be closed – that there is no need for a distinct social role of disability. The medical model, of course, is usually articulated so as to be invalid as an explanatory instrument by definition.

Nevertheless, the models exert considerable influence in the production of discourse, not only by providing the submission instructions for peer-reviewed journals, but also by forming the basis for consultative statements on legislation and policy, activism, cultural initiatives, etc. The question is the extent to which the models become restraints rather than tools, restraints both on action and thought.

4.1 Models and discourse

One of the goals of the following is to represent these models in a way that will display both their strengths and limitations in relation to particular goals. The models are delimited by sets of *topoi*, i.e. parts of argumentative discourse that link up with the *doxa* or background knowledge of the audience. In the context of disability studies, I'm mainly interested in topoi that frame disability as a particular kind of epistemological object. A strong tendency in the development of theoretical models, even a necessary stage, is the rigorous definition of the concept at the center of the model. But particularly in the case of the social model, a definition which "locates the causes of disability squarely within society and social organization"(Oliver 1990: 11) is far less problematic in the context of political action than in the context of philosophical and scientific explanation.

The topography that has shaped the discourse of the social model is that of rights and oppression, of "hard" policy topics such as employment, education, transportation, and the built environment. The social model is easily applicable in these areas because they are relatively amenable to the goal of locating an external cause of disability. Employers discriminate against disabled job applicants, out of ignorance, prejudice, or simple economic rationality. Schools and universities have been slow to recognize the need for physical and other forms of access to classrooms, educational material and services. Public and private institutions of various stripes usually need to be compelled by law into providing equal access. In all of these cases, the disabling process can be documented and causally located in social, political or economic organization.

In the case of "soft" areas, however, particularly interpersonal relationships, the identification of an external, systemic cause of disability is more problematic. The insistence of some social model advocates upon a complete separation between impairment and disability, between the physical and mental capacities of individuals and the mechanisms of society, has proved a dead end. Other forms of the social model have been proposed and developed, but this almost always requires that researchers engage directly with discourse that is usually associated with the medical model. When describing the salient features of specific impairments, it is difficult to avoid the vocabulary of illness, pathology and deviation. The association between such a vocabulary and the at times very repressive regimes of medical intervention and coercion, however, is strong and enduring. Additionally, medical discourse on disability is to a great extent produced by the medical professions, in which the connection between disability and social organization is much weaker than e.g. in the social sciences.

When the social model "locates the causes of disability squarely within society", it highlights both certain aspects of what it is to be disabled – e.g., being excluded from certain buildings, services, and social roles – and permits inferences about how this situation can be altered by means of social change. When the medical model prioritizes methodological individualism, an exclusive emphasis on the biophysical aspect of disability severely restricts the range of possible inferences. Hence Mike Oliver's rephrasing of a survey form, in which questions like "What complaint causes your difficulty in holding, gripping or turning things?" were replaced with questions like "What defects in the design of everyday equipment like jars, bottles and tins causes you difficulty in holding, gripping or turning them?" (Oliver 1990: 7-8), accomplishing a shift in discourse frame from medicine ("complaint") to design and social structure.

The key here is the *bridging* function of the topos, which is recognized by Ruth Wodak:

> [...] 'topoi' or 'loci' can be described as parts of argumentation which belong to the obligatory, either explicit or inferable premises. They are the content-related warrant or 'conclusion rules' which connect the argument or arguments with the conclusion, the claim. As such, they justify the transition from the argument or arguments to the conclusion. (Wodak and Meyer 2001: 74)

In the Oliver example, the topos of *social/societal causation* justify the conclusion that *design is at fault* from the data that *there is difficulty in holding, gripping or turning things.* But the topos of social/societal causation only explains *some* aspects of disability. It is germane to some purposes, but not to all. Explaining the socioeconomic dimensions of disability creation cannot be completely separated from discussions of bodily impairment – or vice versa, as public health professionals know.

4.2 Models and dichotomies

Dichotomouos topoi abound in the established models of disability. The social model is built on the binary opposition between bodily impairment and societal disablement; the medical model classifies people into *healthy* individuals and *pathological* individuals, divides the *normal* from the *abnormal*, and matches *illness* with *treatment*. From such conceptual pairings, it follows that people are either sick or healthy, normal or abnormal, employable or unemployable, and ultimately that "disability" is a clearly delimited, life-defining category. The historian Paul Longmore, for instance, recounts his experience of being trapped between two topical fields. US policy in the 1970s allowed for financial aid towards education for disabled people, but defined disability as "the total inability to engage in "substantial gainful activity"" (Longmore 2003: 236), making financial assistance incompatible with part-time work. Employers, however, are unlikely to hire anyone who entirely lacks work experience. Conversely, the social model's key dichotomies, such as *access/barriers*, *disablement/enablement*, and *personal tragedy / systemic oppression* are apt for analysis of many political and socioeconomic arrangements, but become problematic to the point of uselessness when applied to many forms of social interaction.

This is both a problem of theory and a problem of discourse. The models of disability could be applicable to different situations. Because they are perceived as mutually exclusive, however, their relative explanatory strengths are not recognized. This must be explained with reference to their epistemological ambitions – they are theoretical constructs as well as activist tools, and they are meant to have full explanatory power. Thus, research which could be perceived as complementary is understood instead as belonging to competing traditions.

The ambition and hope for a Grand Unified Theory of Disability is far from harmless. A case in point is the debate over Tom Shakespeare's *Disability Rights and Wrongs* in 2006, and over that book's criticism of the social model. Shakespeare, who has been a prominent figure in UK Disability Studies since the 1990s, wrote that:

> I have come to the conclusion that the British social model version of disability studies has reached a dead end, having taken a wrong turn back in the 1970s, when the Union of the Physically Impaired Against Segregation (UPIAS) social model conception became the dominant UK understanding of disability. (Shakespeare 2006: 2)

The debate that followed was acrimonious and heated. Mike Oliver, who is a quadriplegic, wrote that Shakespeare, who has achondroplasia, "fails to understand the critical reality of impairment and the effect it has both on life and academic work." (Sheldon, Traustadóttir, Beresford, Boxall, and Oliver 2007: 232) Other critics were even more strident. Shakespeare was criticized, among other things, for advocating a return to the medical, individual or personal tragedy model – which, let's not forget, has rarely been defended under those names.

Outside of academia, however, social and medical model frames of understanding interact more smoothly; I'll provide one example from my own research. FFO, the largest Norwegian NGO, is a federation which is built on social model principles and goals, while its member organizations all employ medico-diagnostic criteria for their individual members. It seems that the medical and social model are *not* in conflict in this context, because the social model suggests and identifies overarching political-ideological goals for FFO that cannot be specified, developed or reached without knowing the details of FFO's member organizations' individual members' impairment (Grue 2009).

In this particular, practical context, the social model cannot become politically effective without an appeal to medical knowledge. Simultaneously, it is difficult to frame a large-scale political project in the disability field without recourse to the social model – and social theory – because of the limitations of the medical approach.

4.3 Conclusion: Opening Up Disability Theory

The question, then, is how to approach disability studies in general and theorizing about disability in particular. I propose that discourse analysis has a considerable part to play in this endeavor. First, because discourse analysis can show how the current models grew out of different discourses, and provide an outside perspective on the potential for integrating them. Second, because discourse analysis can make explicit how the models must be rephrased and rethought when applied to the vast and varied fields of discourse production in which disability is currently being introduced as a key concept. This goes not only for legislation, but also for bylaws, codes and regulations in the public, private and civil sector.

Any theory of disability will never entirely or precisely fit every empirical example, but must be continuously tweaked, readjusted and improved. As the paper-producing machinery of journals, peer-reviewers and reciprocal citations has been built in the disability field, so the social model, the minority model and to some extent the gap model have become effective turbines for generating academic discourse.

Analyzing or redescribing the models of disability as engines of discourse does not preclude viewing them as historically significant and effective agents of social change. But by means of their entrenchment in a separate academic field, they are reifying disability as a phenomenon of epistemological interest first and a

sociopolitical disadvantage to be ameliorated second. That way, insularity lies. The other way is one of interdisciplinarity, including engagement with various forms of discourse analysis. It is crucial to preserve the analytical scope and ambition of disability theory, and to engage fully with the areas in which sociopolitically powerful discourse on disability is being produced.

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